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ABSTRACT

This document contains an interim report on the Head Start/Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Collaborative Effort, a demonstration program that was initiated by the Office of Child Development in 1974. The report is primarily a presentation of the data collected from February 1975 to June 30, 1975, concerning six aspects of the Head Start/EPSDT Collaborative Effort during its first year: (1) Medicaid status of children participating in EPSDT, (2) previous health care status of participating children, (3) organization and operation of EPSDT components in the selected Head Start projects, (4) interactions between Head Start selected projects and the state and local agencies responsible for the provision and administration of EPSDT services in the target states, (5) characteristics of the state EPSDT plans and their operations in the target states, and (6) technical support provided and additional need for technical assistance. Information pertaining to medical services and service evaluation is not included. A tentative statement of findings on each of these aspects has been included, but the primary emphasis in this interim report is on the presentation of data in tabular form. (Author/JMB)

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REVISED INTERIM REPORT ON EVALUATION OF HEAD START/EPSDT COLLABORATIVE EFFORT

Prepared for:

OFFICE OF CHILD DEVELOPMENT

March 1976

Prepared by:

Boone, Young & Associates, Inc.
551 Fifth Avenue
New York, New York 10017

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Introduction

This is an interim report on the Head Start/Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Collaborative Effort, a demonstration program that was initiated by the Office of Child Development (OCD)/HEW in 1974. In initiating the program, OCD/HEW set forth the following objectives:

- to assess the benefits in terms of increased services for both Head Start and non Head-Start children and to establish the dollar value of these services
- to determine any barriers which prevent the Head Start program from making maximum use of Medicaid/EPSDT to pay for required health services provided to medicaid elibible children enrolled in local programs.
- to analyze certain long-term program and policy issues concerning Head Start services to young children as a basis for improving those services in Head Start/Medicaid EPSDT.

This report which has been prepared by Boone, Young & Associates, Inc., a private consulting firm under contract with OCD/HEW to evaluate the Head Start/EPSDT Collaborative Effort, is primarily a presentation of the data collected from February 1975 to June 30, 1975, except for information pertaining to medical services and service evalution. The report describes six aspects of the Head Start/EPSDT Colloborative Effort during its first year:

- Medicaid status of participating children in EPSDT (Head Start and non-Head Start enrollees)
- Previous health care status of participating children (Head Start and non-Head Start enrollees)
- Organization and operation of EPSDT components in the selected Head Start projects
- Interactions between Head Start selected projects and the state/local agencies responsible for the provision and administration of EPSDT services in the target states
- Characteristics of the State EPSDT Plans and their operations in the target states
- Technical support provided and additional need for technical assistance.

A tentative statement of findings on each of these aspects has been included but it should be noted that the primary emphasis in this interim report is on the tabulation and presentation of the data in tabular form. The final report will include the medical services and service evaluation data and thereby afford the opportunity for in-depth comparative analysis.

Boone, Young & Associates wishes to extend its gratitude to the OCD staff for its cooperation in implementing the evaluative study design. We also wish to expressly thank the staff of the funded projects, without whose cooperation this study would not have progressed.

Organization of Interim Report

Section I summarizes the major findings from the data collected at this time.

Section II describes the background of the Head Start/EPSDT Collaborative Effort and this evaluation, and also outlines the study methodology.

Section III presents baseline data on all the funded projects that participated in the demonstration. It also provides data on the characteristics and status of children receiving EPSDT services in terms of their Head Start enrollment, Medicaid eligibility and previous health care.

Section IV presents an analysis of the organization and operation of the Head Start/EPSDT Collaborative Effort and identifies some process outcomes.

Section V describes relations with concerned federal, state, and local agencies. State EPSDT Plans are tentatively analyzed. Process outcomes to date are analyzed as well as associated problems.

Section VI presents basic information on costs and Section VII identifies some of the situations and factors impeding effectiveness of the Head Start/EPSDT Collaborative Effort.

Appendix A consists of a list of the tables that will be developed for the final report. Appendix B is a profile of the target states and lists the salient characteristics of the selected projects in those states. Appendix C provides copies of data collection forms and instructions. Appendix D shows the entry instruction for all tables.

I. SUMMARY OF MAJOR FINDINGS

In order to carry out the objectives of the Head Start/EPSDT Collaborative Effort, OCD/HEW awarded supplemental grants to 200 Head Start projects to mount the demonstration program. This group constituted the national sample for the evaluation study.

OCD established several priorities for these demonstration projects during the first year. The most important priority was to provide EPSDT services to as many Medicaid eligible Head Start children as possible and enroll in Medicaid the maximum numbers of Head Start children not yet certified by the medical assistance program. As a second priority, Head Start projects were to conduct community-wide recruiting for non-Head Start Medicaid eligible children. For this population also, the projects were to assure certification of the Medicaid eligible children.

For the Head Start projects, however, the first year of operation for the collaborative effort was primarily a developmental period with many trial and error learning experiences. During this period, the demonstration projects had to phase in the collaborative effort as well as familiarize themselves with the various forms being used in the evaluation study.*

The Head Start projects did reasonably well in meeting the priorities set by OCD, despite the inevitable lags inherent in tool-up activities. According to the information obtained from the data collection instruments, 57,133 children participated in the Head Start/EPSDT Collaborative Effort at some time during the program year. It should be understood, however, that it is anticipated that 90,000 or more children will through this effort during the first year.

Note: The above estimate is based on the following calculation re: cumulative participation, participation at intake, and planned vs. participation.

- 53,557 participation at intake (176 projects)
  -38,417 participation at intake (120 projects)
  15,140 (add to cumulative participation total

- 57,133 cumulative participation (127 projects)
  +15,140
  72,273 = total of 176 projects/cumulative participation

- 25,000 = planned population to be served of number of projects not submitting any information

- $\frac{\text{planned}}{\text{cumulative}} = 74\%$ $.74 \times 25{,}000 = 18{,}500$

- 72,273
  +18,500
  90,773 = anticipated population to be served

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* During the first year of implementation, two projects were eliminated from the Collaborative Effort. One project, the Mississippi Band of Choctaw Indians, returned the grant to OCD. Another project, the Genessee County C.A.A. was unable to accept the grant at the time because of complex local conditions. Thus, for purposes of this evaluation, the universe studied is 198 projects.

The more immediate concern of the data analysis pertaining to participation was to determine the nature and extent of the participation, during the first year, by various categories of Head Start and non-Head Start children. Therefore, a baseline group was devised consisting of 120 projects as these had submitted both the Health Care Intake Form and the End-of-Year Status Forms, each of which had been designed to report various aspects of participation in the collaborative effort.

Other significant findings from the first year effort included the following:

- the majority (60%) of both Head Start and non-Head Start children reported as Medicaid certified began with that status
- nearly all of the previously enrolled Head Start Children (92%) had received screening services prior to entry into the collaborative effort
- relationships between Head Start projects and state local Medicaid agencies were very informal; most agreements between these entities were verbal in nature
- State Medicaid/EPSDT plans varied from state to state and were often very complex depending on the state
- very little technical assistance was provided to Head Start projects; many projects took the initiative on their own to implement the various objectives of the EPSDT Collaborative Effort.

In assessing these findings, it should be particularly noted that a relatively low number of non-Head Start children were recruited during the first year effort. Moreover many did not realize the potential for service to non-Head Start children through utilization of non-Head Start community resources. In some cases, however, demonstration projects were stymied by the reaction of public agencies or the difficulty of intermeshing with the existing public Medicaid/EPSDT system.

On the positive side, Head Start programs initiated relationships with many public welfare, Health and social service agencies, and private sector providers, and reinforced existing contact with such groups. In some target states, Head Start programs stimulated greater interest in EPSDT within local communities and among concerned state agencies. Reviewing the level of participation in terms of number of children against the generally limited technical support received by the demonstration projects, the level of activity--varied greatly among individual projects--is understandable and, in some instances, commendable.

Tentative findings, based upon currently available data, are detailed below. For purposes of presentation, these findings are keyed to the six aspects of the Head Start/EPSDT Collaborative Effort which are the focus of this report.

SPECIFIC FINDINGS

A. Medicaid Status

- Of the *5[illegible],189 children participating in the EPSDT Collaborative Effort, only 49% were Medicaid certified on a cumulative basis. There was a greater proportion of these Medicaid certified children among non-Head Start (83%) than among Head Start Children (38%)
- The majority of the non-Head Start children were siblings of Head Start enrollees
- The majority of children--Head Start and non-Head Start--who were reported as Medicaid certified began the EPSDT Collaborative Effort with that status (60%)
- There were large variations between regions and between selective projects on the above findings.

B. Prior Health Care

- Nearly all of the previously enrolled Head Start children (92%) had received screening services prior to entry into the EPSDT effort. These children had also received dental services at a greater rate than any other medical care. (One out of three children have received such services). Medicaid certification or eligibility was not a factor in the receipt of these services.
- Few projects reported children--Head Start or non-Head Start--who had received mental health, medical, and nutritional services prior to entry into the EPSDT program. Head Start children who had been previously enrolled received more treatment than others.

  Non-Head Start children who had received health services prior to entering EPSDT were primarily Medicaid certified (73%) and siblings of Head Start enrollees (66%).

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* Represents the total number of children participating in the Head Start/EPSDT Collaborative Effort based on information submitted by the 120 Demonstration Projects being used for baseline data.

C. Primary Characteristics in the Organization and Operation of the EPSDT Services in Head Start

- To a degree there was change in Head Start health services. The area of greatest intervention was outreach; although here again siblings of Head Start children were a major focus.
- A majority of the health service coordinators were full-time personnel with some college background and several years of prior experience in Head Start.
- The organization of EPSDT as an additional responsibility for the Head Start health service components, in many cases, placed severe strain on existing staff.
- Training of staff for their esponsibilities in implementing EPSDT was generally limited, and particularly in the case of non-health staff. The limited training of the non-health staff contributed to their misunderstanding of the collaborative effort.
- Previous approaches used in the Head Start health services, such as outreach, follow-up, and recordkeeping; tended to be maintained for this collaborative effort, with consequent limitations on the level and adequacy of services to non-Head Start children
- There was an absence of realistic and meaningful planning in a majority of the Head Start projects.
- There was inadequate time for developing proposals and implementing them.
- There was confusion as to the objectives of the EPSDT Collaborative Effort.
- There was misunderstanding of its intended operation.

D. Interaction Between Head Start and State and Local Agencies Responsible for Medicaid/EPSDT

- Relationships between the Head Start projects and the state or local agencies responsible for EPSDT were characterized by a focus on local agencies and by informality; i.e., there was only one contract reported

- between a public agency and a Head Start project; verbal agreement was not always carried out; and ongoing contacts were primarily on an ad hoc basis, and frequently by telephone.

- Minimal assistance or support was provided to Head Start projects by public agencies at any level, with the infrequent exception of direct health services where a public health agency was an EPSDT provider.

- Many projects reported resistance by public agencies, particularly at the local level, regarding Head Start roles in the delivery of EPSDT services.

- Many projects continued to rely on their previous patterns of health service arrangements in the case of Head Start children, possibly minimizing the use of Medicaid, particularly since few Head Start projects obtained reimbursements by EPSDT either as vendors or under purchase of service agreements. While achievement of vendor status was not a primary objective in the first year, it should be noted that no project achieved vendor status during the first year, (the Eugene project had such status before the collaborative effort began), although Springfield is scheduled to do so in the near future.

E. State Medicaid/EPSDT Plans

- State Medicaid/EPSDT plans were characterized by their complexity, with variated delegations of responsibility to different public and private agencies at both the state and local level.

- In many instances, there was an absence of provisions for inclusion of community agencies in the delivery of EPSDT services.

- There were limitations in the provision of supportive services, in terms of both the approaches adopted and the resources allocated, including outreach to potential clients and providers, transportation, follow-up and recordkeeping.

- There were inadequacies in administration and maintenance of a low profile activity.

F. Technical Assistance Provided and Needed

- In most cases, Head Start projects had particular technical assistance needs in the following areas:
  - outreach: assistance in planning and developing outreach strategy and interactional relationships with state and local EPSDT agencies for the provision of supportive services for outreach.
  - follow-up: assistance in planning and developing follow-up systems to insure that children who have been screened and diagnosed receive follow-up health services.
- Very little technical assistance was provided to Head Start projects participating in the EPSDT Collaborative Effort

  Particularly evident was the lack of assistance from the Health Liaison Specialist, who visited various projects, but provided minimal support/assistance.
- Responsibility for negotiating with state/local Medicaid agencies for vendor recognition of the demonstration project was not pinpointed. In most cases, this never occurred. Virtually all of the demonstration projects remain without vendor status and reimbursement for the many EPSDT services--both health and supportive services--they provide.

II. BACKGROUND AND METHODOLOGY OF THE EVALUATION

This section presents a discussion of the background of the Head Start/EPSDT Collaborative Effort and describes the study methodology and associated problems. Methodological topics include: The Choice of Selected Projects, Data Collection and Recordkeeping System, Site Visits, Data Processing and Analysis.

Background of Medicaid/EPSDT

The 1967 Amendments to Title XIX of the Social Security Act (Medicaid), mandated a new program of preventive health services through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) of children ages 0-21 from low-income families. As a result of this legislation, states have been required to move expeditiously in establishing health services for poor children and youth that might serve to prevent illness or permanently handicapping conditions. These amendments to the Social Security Act were enacted on January 2, 1968 and became effective in July 1969. The Social and Rehabilitation Services/Medical Services Administration of the Department of Health, Education and Welfare is the administering agency for the Medicaid/EPSDT program.

Guidelines for implementing legislative mandates were first published in December 1970 but the regulations themselves were not issued until November 1971. These regulations, currently in effect, extended the date for full implementation of the EPSDT program and allowed the states to initiate these services by apportioning the children to be served on the basis of age. The age group to be served first was to include those children ages 0-6, with services gradually expanded to include all youth up to age 21 by July 1, 1973. It should be noted that the federal legislation provides for penalties to be levied against those states who do not provide for full implementation of the EPSDT program within the specified time period.

EPSDT is an integral part of Medicaid, the federally reimbursed medical assistance program. Therefore, the rules and regulations that pertain to the administration of Medicaid are applicable to EPSDT as well. The medicaid program can be characterized as a federal-state financed, state administered program with the federal contribution varying from 50% to 83% of medical cost, depending upon the unique features of an individual state plan. Medicaid (and EPSDT) is usually administered on the state level by the state public welfare department. In general, the problems that have been identified in the administration of the Medicaid program apply to EPSDT as well.

The characteristics of the Medicaid program vary greatly from state to state. The federal guidelines for Medicaid are broad and general and only certain basic services are mandated. Thus, states have wide latitude in defining the scope and nature of the Medicaid services to be provided within their area. Rather than being viewed as one uniform national program, Medicaid can best be described as a program which is administered on the basis of 49 separate state plans which resemble each other only in their basic minimum requirements. (The state of Arizona does not participate in the Medicaid program.)

Individual state plans provide varying definitions for Medicaid services in several areas.

1. Elibibility level: All states must serve the categorically needy as defined by federal public assistance titles but the state has the option of setting definitions for serving the medically indigent, i.e., they can determine the criteria for serving low-income families who are not public assistance recipients.
2. Provider status: The state can decide which providers of medical services can be awarded vendor status and thus restrict the category of persons or groups to be reimbursed for services rendered to the Medicaid population. In some states, only licensed private physicians are reimbursed; while in other states, services rendered by neighborhood clinics or nurse clinicians are reimburseable also.
3. Benefit Structure: Beyond the minimum services required by law, the states have the option of determining whether additional benefits will be offered to Medicaid recipients.

These benefits can be limited by utilization controls. For example, California Medicaid recipients are permitted two physician visits per month (except for EPSDT services).

4. Reimbursement Rates: States determine the rate at which providers are reimbursed for services rendered. Reimbursement methods range from payment for "reasonable cost" to a flat rate for specific services which bears little relationship to the cost of the same service in the private sector.

5. Billing and Collection Procedures: Billing and collection procedures also vary from state to state and may affect the submission of bills and the frequency and rapidity of payment to providers. Although this particular area has definitional relationship to the provision of Medicaid services, it has impact on the extent to which providers will participate in the program. For instance, in many states, there is a lag of several months between the time a service is rendered and payment is received by the provider. This factor together with low reimbursement rates tend to reduce the number of providers participating in the Medicaid program.

Effect Upon the Delivery of EPSDT Services

The problems inherent in the administration of the Medicaid program, both in terms of the provision and definition of services as well as the overall management, have immediate impact on the scope and nature of the EPSDT program and present problems for its implementation. Federal requlations for EPSDT designate state Medicaid agencies as the responsible unit for providing or arranging health services for children of low-income families. This responsibility includes locating and informing families with eligible children of service availability as well as securing providers of EPSDT services. In some localities there is a minimum number of providers and medical services are generally unavailable. Thus the development of a linkage system whereby eligible children can be routinely referred to receive EPSDT services poses a major problem for planning and administration.

Many state Medicaid agencies do not perceive that they have a primary role in delivery of health services. Indeed, most of these agencies are in fact public welfare agencies who find their time consumed in the administration of public assistance and social services. Therefore, little priority is placed upon these developments and provisions of comprehensive preventive health services.

Genesis of the Collaboration Between Head Start and Medicaid/EPSDT

In 1973, the Office of Child Development (OCD) and the Medical Services Administration (MSA) discussed the possibility of a collaboration between the Head Start and EPSDT programs. The rationale behind this exploration was recognition by these agencies that:

- the goal and objectives of the health services components of Head Start and Medicaid/EPSDT are mutual, since both focus on prevention, identification and treatment of illness, and linkage of the child and family to an ongoing health system

Both OCD and MSA serve primarily the same clientele--low-income families--and both agencies are concerned with continuity of care and achieving the objective of health services integration. Thus, it was felt that this common frame of reference could serve as a catalyst to generate a wide range of local collaboration and cooperation between the two programs that would help to strengthen Head Start health components and assist state and local agencies in administering and implementing EPSDT programs.

On December 12, 1973 a joint memorandum announcing the collaboration was circulated from Howard Newman, Commissioner of MSA, and Saul Rosoff, Acting Director of OCD, to their respective program directors in the HEW regional offices. The plan, as described in the transmittal notice, was to fund 200 Head Start projects which would help make EPSDT services available to Medicaid eligible children 0-6 years. Head Start would refer potentially eligible children to Medicaid for certification and in turn, Medicaid would supply EPSDT services in accordance with the state Medicaid/EPSDT plan. Any additional health services for Head Start children not covered by the state Medicaid plan but required by the Head Start Performance Standards would be paid for by local Head Start programs.

The Head Start projects approved for participation in the collaboration effort would assist the Medicaid/EPSDT agency by providing health-related support services, including case findings, transportation, public information, referral and follow-up services.

The Head Start projects were also assured that eligible children would receive the EPSDT services to which they are entitled. In addition the collaboration effort called for projects to provide services to non-Head Start children, including siblings of Head Start enrollees and other potentially eligible children in the Head Start target area.

On December 18, 1973, the Office of Child Development issued guidelines for the collaboration effort. The collaborative program was established as a demonstration effort for one year, with the possibility of continuing a second year. Staff already employed by Head Start programs in local areas were to perform the core activities of the demonstration effort. Supplemental grants would be made available to hire additional staff or increase working hours of staff already on board. The health services coordinators in the Head Start program were to be responsible for implementing the collaboration as well as directing and coordinating all health services. Their broadly stated responsibilities included: informing families of the existence of the collaboration; arranging for transportation; aiding families in establishing Medicaid eligibility; assisting in securing medical appointments for eligible children; maintaining health records to assist in tracking the provision of care for each child and arranging for follow-up and referral.

In addition, the health services coordinator was to serve as liaison to the child and the family, the public welfare and health officials and local health providers. The Head Start programs selected for the demonstration were to provide health-related support services for those Head Start and non-Head Start children recruited for participation in the EPSDT Collaborative Effort.

OCD guidelines stated that the objective of the collaborative effort was to "demonstrate the applicable approaches for bringing about local collaboration among Head Start programs, state and local Medicaid agencies, and related health resources in the delivery of EPSDT services." The guidelines also expressed that local Head Start projects were to make maximum use of state Medicaid/EPSDT plans to pay for health services rendered to Medicaid certified children.

The criteria used by OCD to select grantees for the collaborative effort included: a project's willingness to participate in the collaboration; the project's ability to implement health services for children; state Medicaid agency support of the collaboration; the project's ability and willingness to enroll and serve all the Medicaid eligible Head Start children. For those projects serving non-Head Start Medicaid eligible children it was necessary to identify a significant number of children in the target area who were age 0-6. Priority was to be given to programs able to enroll in Medicaid/EPSDT the maximum number of Head Start children who were not presently served by Medicaid. A second, but important, priority consideration was given to the project's ability to enroll in Medicaid/EPSDT substantial numbers of non-Head Start children who were not covered by Medicaid.

OCD announced that technical assistance would be provided through contract with the American Academy of Pediatrics (AAP) and its health liaison specialists. The specialists were to assist the local Head Start grantee in making collaborative arrangements with Medicaid agencies. They were also to provide orientation and training sessions for the Head Start health services coordinators and assist them in planning and implementing the collaborative effort.

On January 10, 1974, after the distribution of the OCD/MSA memorandum and the guidelines for the Medicaid/EPSDT Collaborative Effort, the Commissioner of the Social and Rehabilitation Services, James Dwight, Jr., advised SRS regional staff to withhold implementation of the directive set forth in the OCD/MAS memorandum of December 12, 1973. He requested instead, advice from the regional staff on the feasibility for pursuing the collaborative effort. It appears that the decision to mount a collaborative effort between Head Start and EPSDT programs had not received the necessary clearances from SRS executive staff, nor had sufficient input been sought from regional personnel regarding its efficacy.

Subsequently, the SRS Commissioner approved the collaborative effort and authorized the staff, in a memorandum dated February 14, 1974, to proceed in implementing demonstration programs. He stated however, that "the Federal Government will not directly engage in outreach and will not require any state to engage in outreach to secure additional eligibility for the Title XIX program,"* which he felt was a prerogative and choice strictly limited to the state. Furthermore, he stated that the Head Start demonstration project was to be used in "making EPSDT services available to Medicaid eligible children who are also enrolled in Head Start." Conceding that outreach is a necessary component in such a program, the SRS Commissioner stated that concurrence from the state Title XIX Directors and the Governor was to be received before any such activity was initiated in any state.**

It is clear from the various memoranda and guidelines issued by the two federal agencies involved in the collaborative effort that there was considerable confusion between them about the objectives of the demonstration program. The December 12,1973 OCD/MSA memorandum set forth a policy of outreach by the Head Start program to recruit low-income families who were not customary users of the Medicaid system. Further, the Rosoff Memorandum of August 1974 had indicated that the Head Start program would provide a public information function regarding the availability of EPSDT services. The Head Start program would therefore not only provide EPSDT services for its own Medicaid eligible enrollees, but would also reach out to Head Start children not previously enrolled in Medicaid as well as siblings and other low-income families in the community. OCD speculated that 75,000 previously non-enrolled Head Start children, and an additional 50,000 non-Head Start Medicaid eligible children ages 0-6 would be reached through this effort.* From the viewpoint of the SRS Commissioner, however the state Medicaid agencies had the primary responsibility for initiating outreach and recuitment activities for EPSDT services. Moreover, he viewed EDPST as a complementary, rather than as a substitute health services program for Head Start.

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* James Dwight, Jr. - Memo to SRS Regional Commissioners, February 14, 1974.

** Ibid.

Study Process

In May 1974, the Office of Child Development issued a request for proposals to perform an evaluation study of the Head Start/EPSDT Collaborative Effort. The purpose of the evaluation, according to OCD was to assess the extent to which the collaborative effort had been successful in achieving its goals and objectives by tracking the outcomes of the demonstration program. Boone, Young & Associates, Inc., was awarded the contract for the evaluation in June 1974.

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* OCD Operational Planning System, Objective and Operation Plan, Fiscal Year 1974, June 5, 1974.

The initial month of the evaluative study entailed the development of a framework for data collection, analysis, and reporting. The study design was reviewed with OCD staff and agreement reached on the analytic study to be utilized. The target states for the study were also agreed upon, and included one state from each region and two from Regions IV and V. Also, it was agreed that the projects selected for in-depth analysis would be drawn from these target states. The data collection instruments were submitted by the evaluation team to OCD for approval. It was agreed that the scope of the forms would be such that the burden for data collection would be minimized for the demonstration projects during the course of study. The data collection instruments included: Intake Form, Staff Profile Form, EPSDT Medicaid Profile Form, Expenditure Form. Encounter Form, Composite Visit Form, Time Utilization Form and Income Sources Form.

During the period that data collections instruments were being finalized, the evaluation team was asked to participate in a series of cluster workshops to provide an overview of the evaluation and the data collection instruments to the demonstration projects. Boone, Young & Associates' staff attended workshops in Denver Colorado, Silver Springs, Maryland and Dallas, Texas. At the workshops, the participating Head Start projects were given draft reporting instruments and were provided with explanations of the purposes of the forms. These workshops also provided the opportunity to clarify for the Head Start projects the purposes of the evaluation as well as the overall objectives of the collaborative effort.

OCD requested that additional sessions be held to train the Head Start health coordinators in use of the data collection instruments. During November and early December, Boone, Young & Associates staff and the members of OCD Program and Innovation Division provided training for the health coordinators in sessions held at the regional level.

Implementation

In January 1975, the various forms and instructions were mailed to the 198 Head Start demonstration projects. In addition, OCD sent letters to the projects and program directors officially informing them of the evaluation. Separate letters were sent to the 30 projects informing them of their selection for in-depth analysis.

The Boone, Young & Associates evaluation team established a procedure whereby the demonstration project could make telephone inquiries regarding the completion of the data collection instruments and other aspects of the evaluation. They also provided some technical assistance to individual projects experiencing difficulty in completing the data collection instruments. For instance, specific advice was given on how to utilize parents and volunteers in mounting recruitment efforts; ways to deploy limited staff more effectively; and techniques for obtaining information on available Medicaid/EPSDT services. It should be clearly noted that such information was provided only upon request from the projects.

In early February 1975, the first group of completed intake forms were received. There have been variations in the efficiency of form completion among the demonstration projects. Considering that there was some resistance to the evaluation study by many of the demonstration projects, the submission of data has been of high quality.

As of June 30, 1975, 184 out of the 198 funded projects (93%) had submitted data, utilizing one or more of the study instruments. As of the same date, however, no project had submitted all of the required forms. The intake form had the highest rate of return, 176 out of 198 projects reporting, or 89%. Conversely, the lowest rate of return was recorded for the income and expenditure reports. On all other forms, the rate of return was better than 60%. Even though the program year has ended, some demonstration projects are still submitting data. Thus, the eventual rate can be expected to increase.

Return by the 30 selected projects has been below the rate of return for the universe. Moreover, six selected projects chose not to participate fully in the evaluation.

The planning of the on-site visits and the development of the Ad Hoc Questionnaire began after the forms were distributed. The design of the Ad Hoc Questionnaire was based upon information gleaned from Head Start regulations and guidelines as well as impressions received from the various telephone inquiries of the health coordinators. The purpose of the Ad Hoc Questionnaire was to collect information on qualitative issues which would be supplemental to the information presented through the data collection instruments. There was joint agreement with OCD that the Ad Hoc Questionnaire would be used as a discussion guide so that Boone, Young & Associates staff conducting on-site visits would address comparable areas with local Head Start programs.

A site visit schedule was provided so that all selected projects would be visited in the most rational and cost-efficient manner. Teams consisting of two evaluation staff members visited the sites during the months of April, May and June, 1975. In most cases, the same staff members visited all the projects in the region so that they would have a comprehensive view of that particular area. Whenever possible, the staff members met with representatives of the Medicaid agencies and the providers of Medicaid services serving the project. Five projects were not visited because they had not completed the data collection forms.

Analysis

Throughout the course of the evaluation study, Boone, Young & Associates attempted to collect copies of the EPSDT plan of the target states. For this report, the available plans have been analyzed according to their organizational and administrative structure.

As the data collection forms were submitted by the projects, Boone, Young & Associates staff reviewed the data for gross errors and prepared them for data processing. Phone calls were made to the projects to verify or correct incomplete or inaccurate information. Particular attention was paid to the coding of responses related to status with regard to Head Start, Medicaid eligibility, and previous health care. Additional cleaning/editing functions were performed through data processing.

During May, June and July the analytic tables were finalized for the presentation of this preliminary report.

Methodology

The evaluation of the Head Start/EPSDT Collaborative Effort required:

1. the selection of projects for in-depth analysis
2. the development of a series of data collection instruments which constituted the required recordkeeping system
3. data collection on all site visits to the selected projects
4. data processing
5. data analysis.

The relationship between these elements is shown in Exhibit No. 1.

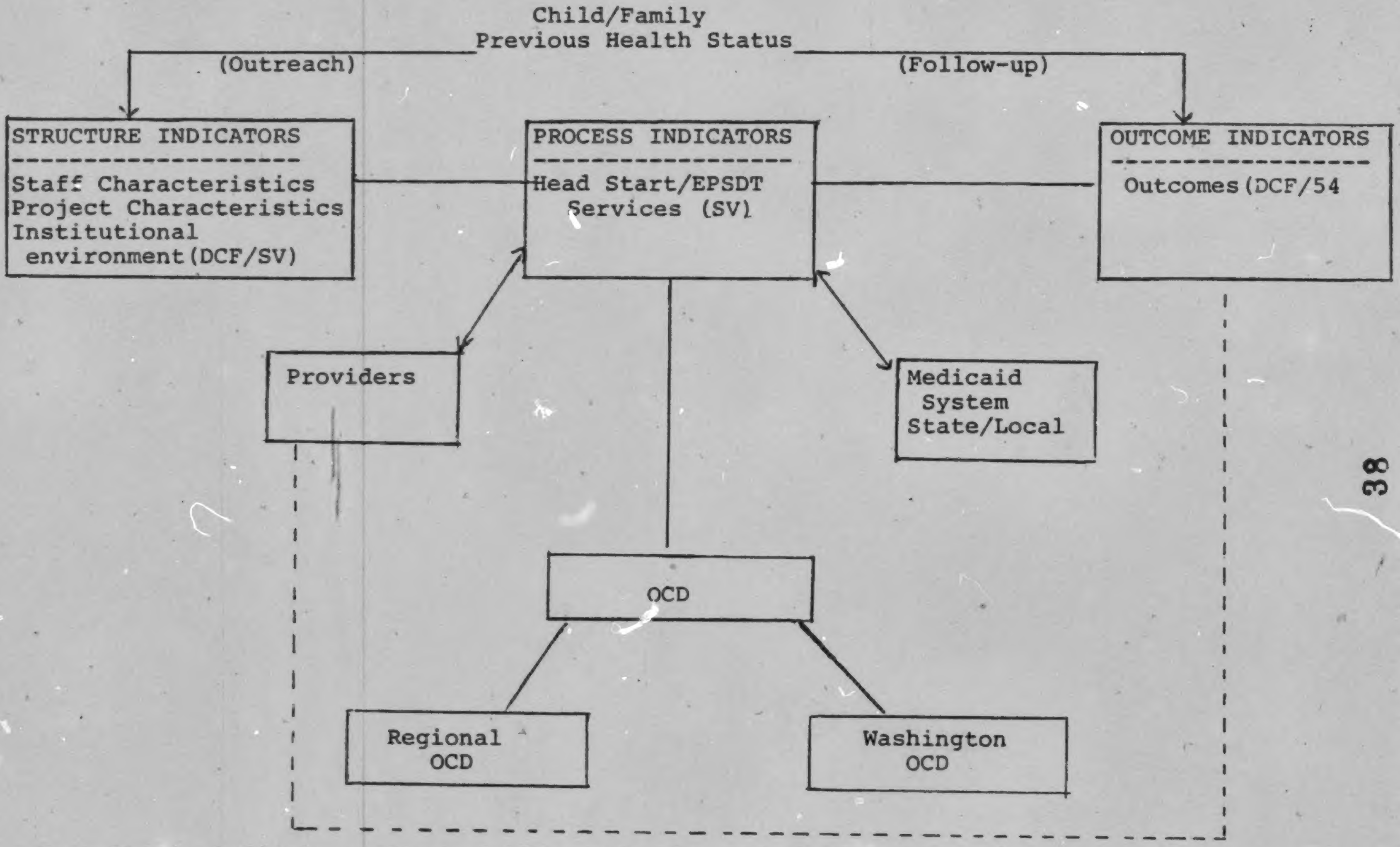
Project Selection

Thirty projects were selected from the universe of 198 demonstration sites funded for the Head Start/EPSDT Collaboration Effort for in-depth examination and analysis. The sites were chosen within the twelve states designated as target states by the Office of Child Development for this evaluation. These states were: Massachusetts, New Jersey, Maryland, Mississippi, Tennessee, Illinois, Ohio, Texas, Missouri, Montana, California, and Oregon.

Head Start is a national program which allows for sufficient flexibility at the local level to be responsive to community needs. Medicaid/EPSDT programs also vary at the state and local level in regard to policy initiatives. Examination of the universe of 198 projects reveals few similarities among the projects because of the highly diversified nature of these programs. It was therefore difficult

EXHIBIT I

EVALUATION INDICATORS FOR HEAD START/EPSDT COLLABORATIVE EFFORT


Child/Family
Previous Health Status
(Outreach)
(Follow-up)
STRUCTURE INDICATORS
Staff Characteristics
Project Characteristics
Institutional environment (DCF/SV)
PROCESS INDICATORS
Head Start/EPSDT Services (SV)
OUTCOME INDICATORS
Outcomes (DCF/54
Providers
Medicaid System State/Local
OCD
Regional OCD
Washington OCD

Parenthesis indicate sources of information by methodology component:
DCF: Data collection forms
SV: site visits to selected projects
Data processing is not shown but is applied to develop previous status and outcome indicators

EXHIBIT II

CHARACTERISTICS OF SELECTED PROJECTS

TARGET STATES AND SELECTED PROJECTS	RURAL/ URBAN	RANGE OF PROGRAM SIZE WITHIN STATE	FUNDING LEVEL	NUMBER PLAN TO SERVE	PROBLEMS AND INSTITUTIONAL CHARACTERISTICS							
					Provider Problems	Client Education	Transportation	Welfare Agency Problems	Problems With ID of Eligibles	Lack of Preventive Health Services	Insufficient Health Resources	Lack of Follow-up
MASSACHUSETTS (I) Leominster	R	60-405	210	50	X		X					
Worcester	U	60-405	405	650						X		X
NEW JERSEY (II) Toms River	R	120-440	150	200	X		X				X	
Paterson	U	120-440	180	4750	X					X	X	X
Trenton	U	120-440	290	200	X		X					
MARYLAND (III) Baltimore	U	60-463	463	150		X	X					
Centerville	R	60-463	152	150	X	X						X
MISSISSIPPI (IV) Bolivar	R	140-2745	2508	250	X		X	X				
Tougaloo	R	140-2745	1428	1169		X					X	
TENNESSEE (IV) Kingston	M	140-580	140	488			X					
ILLINOIS (V) Cook County	U	240-7276	1080	5000						X	X	X
East St. Louis	U	240-7276	390	689		X						
Danville	R	240-7276	260	92	X		X					
OHIO (V) Cincinnati	U	135-1158	985	2000		X	X				X	
Dayton	M	135-1158	360	--								

Code:

R = Rural U = Urban M = Mixed

EXHIBIT II
(Cont'd.)

II-20b
CHARACTERISTICS OF SELECTED PROJECTS

TARGET STATES AND SELECTED PROJECTS	RURAL/ URBAN	RANGE OF PROGRAM SIZE WITHIN STATE	FUNDING LEVEL	NUMBER PLAN TO SERVE	PROBLEMS AND INSTITUTIONAL CHARACTERISTICS							
					Provider Problems	Client Education	Transportation	Welfare Agency Problems	Problems With ID of Eligibles	Lack of Preventive Health Services	Insufficient Health Resources	Lack of Follow-up
OHIO (Cont'd.) Sandusky	M	135-1158	120	250		X		X		X	X	
TEXAS (VI) Amarillo	M	123-277	720	400		X						
Lubbock	U	123-277	260	10								
Houston	M		1650	--				X			X	
Laredo	R	123-277	1277	351	X				X			
MISSOURI (VII) Appleton	R	120-2240	120	600	X							
Springfield	M	120-2240	440	as many as possible.	X							
MONTANA (VIII) Billings	U	120-180	120	266		X	X	X			X	
Blackfeet Tribe	R	120-180	120	100	X							
Fort Peck	R	120-180	180	182		X						
CALIFORNIA (IX) Bakersfield	R	35-353	66-100	267	X						X	
El Centro	R	35-353	300	300	X						X	
Fresno	R	35-353	120	400	X							
OREGON (X) Eugene	M	45-430	120	all within community	X							
Medford	R	45-430	150	--	X		X					

Code:

R = Rural U = Urban M = Mixed

to find a basis of comparison upon which to draw a representative sample. In addition to the highly individualized nature of the projects, the selection process was complicated by other factors, including:

- the lack of baseline data on the funded projects
- the lack of uniformity and completeness of the available data presented in the grants proposal
- the inability to make contact with local projects to verify and collect baseline data because of time constraints
- the necessity of drawing a sample within the characteristics presented by funded projects.

Therefore, it was decided in discussion with OCD that the priority for selection of the 30 projects would be based upon an identification of the various network of barriers, both internal and external, which the local project faced that might impact upon the outcome of the collaborative effort. Efforts were directed at examining programmatic problems and possible solutions to determine what could realistically be expected of the local projects. Options for possible solutions to the problems were also considered.

The following criteria were agreed upon as the basis for selection of the thirty projects:

- identification of institutional barriers to the implementation of EPSDT
- programmatic aspects of delivery of health care to children
- rural/urban characteristics
- program size
- program sponsorship
- geographic dispersion within the state.

The funded projects exhibit a strong rural bias. For example, in states that have densely populated areas, such as New York and California, only a relatively small number of rural programs were funded. Head Start, in general, has a strong urban focus, and large numbers of Medicaid eligible children are generally found in densely populated communities. This selection attempted to compensate for the rural bias by including several large urban areas. With the exception of Paterson, New Jersey and Baltimore, Maryland, the only areas which presented us with the opportunity to study urban areas were in Region V. This explains the slightly higher concentration of selected projects in this region.

A profile of the projects selected for an in-depth analysis can be found in Appendix B of this report. Exhibit II provides additional information.

Data Collection and Recordkeeping System

A set of data collection forms was designed by Boone, Young & Associates. The forms were intended to serve two purposes: 1) to obtain information necessary to the evaluation; 2) to support local projects' recordkeeping activities, particularly as related to the health component and the collaboration between Head Start and state and local agencies administering EPSDT. Copies of the forms and the associated instructions are provided in Appendix C.

The forms provided are:

- Health Care Intake Form: a form to be used by each funded project and completed once for each child participating in the Head Start EPSDT Collaboration Effort, at the time he is first recruited for EPSDT services. It is designed to collect information regarding:
    - the child's Medicaid status
    - the child's status with regard to Head Start
    - the child's previous health record for the twelve months prior to the collaborative.
- Health Care Encounter Form: to be completed monthly for each child in the 30 selected projects only. It is designed to collect data cumulatively by child on the following elements of health care service provided:
    - the type of visit (screening, diagnostic, counseling referral, or treatment)
    - the disposition of the case (including follow-up visits where indicated)
    - the assessed value of the provided services.

- Health Care Composite Visit Form: to be completed monthly by project for the remaining 170 projects. It records information separately for Head Start and non-Head Start children regarding:
  - the total number of visits by type (screening, diagnostic, counselling/referral, or treatment) of children in the project during that month
  - the disposition of cases (the number of referrals, follow-ups, and completed cases).
- End of the Year Status Report: designed to be completed cumulatively by project at the end of the year. Collects information regarding:
  - the participating children's Medicaid status
  - the amount of turnover the project experienced
  - the disposition of medical records.
- Staff Profile Form: designed to record information regarding staffing patterns for the Head Start/EPSDT Collaboration Effort. Collects information regarding the staff's:
  - employment status
  - duties and responsibilities
  - educational background
  - previous employment/experience.
- Time Utilization Form: designed to assess the quarterly distribution of the Head Start/EPSDT staff time to the following categories:
  - direct labor
  - supportive labor
  - administrative labor.

- Income Sources Form: designed to be completed once during the program year to identify the extent to which the Head Start program is making use of available resources.
- Expenditure Form: designed to be completed once a year to collect information on how available resources are used to fulfill the requirements of the Head Start/ EPSDT Collaboration Effort.
- Medicaid Profile Form: designed to be completed by the Health Liaison Specialist. Collects background information on the Head Start projects regarding its status and its understanding of EPSDT Medicaid.

Site Visits

One to two-day site visits were made to 24 selected projects. The purpose of the site visits was to obtain information concerning selected issues surrounding the implementation of the Head Start/ EPSDT Collaborative Effort; for example, start-up activity, relationships and agreements with state/local Medicaid agencies, provider arrangements, etc. The interviewer attempted to assess the projects' understanding of the collaborative effort and to identify barriers which might affect the success or failure of efforts (i.e., arrangements with health providers, general lack of health provider, etc.). In addition, the site visits were used to check the validity and the reliability of the information reported by the projects via the data collection instruments.

Generally, the site visits involved the following sequence of activities:

1. The purpose of the site visit was explained to the Head Start Director, Health Services Coordinator, and other staff working on the Head Start/EPSDT Collaborative Effort at the time of the site visit.
2. The Head Start Director or other responsible staff member was asked to explain the organizational structure of the program.
3. Responsible staff were then asked to elaborate on their understanding of the objectives of the Head Start/EPSDT Collaborative Effort: how they felt about the effort from its inception; how they felt about the effort at the time of the site visits; and what they perceived to be the prospects for its future.
4. Topical areas outlined in the discussion guide on the collaborative effort were addressed; e.g., program staffing, management, outreach, etc.
5. Upon completion of these discussions, a set of data collection forms submitted by the project was reviewed for accuracy by checking records, e.g., the child's medical record.

Wherever possible, meetings were arranged with providers of EPSDT services and staff of the local and/or state Medicaid agencies. Meetings with the health providers focused on their understanding of and attitudes concerning the Head Start/EPSDT Collaborative Effort, and the problems, if any, they had encountered while engaged in this effort. Meetings with Medicaid agency staff were directed toward gaining further insights concerning their roles/practices and policies in relation to implementation of EPSDT.

The field staff received excellent cooperation at the local level. In all cases, the Head Start personnel were cooperative and informative. Medicaid personnel were generally responsive, as were health providers.

The information from these visits is now being analyzed. In addition to supplemental descriptive information obtained through the data collection forms, the selected projects are expected to provide a great deal of material that may be relevant for policy analysis. Particular attention has been directed to examining how the local programs attempted to solve problems.

Data Processing

The objective of the data-processing effort has been to provide comprehensive and accurate summary data for the analysis. Procedures were developed for the processing of enrollment, Medicaid and previous care status data from the Intake Forms, which are the basis for much of this interim report. Procedures for processing receipt of EPSDT health services data from the Encounter Forms will be described in the final report.

There were four distinct phases involved in the processing of the intake data:

Phase I - Prepare Data
Phase II - Clean Data and Create Permanent Disk Files
Phase III - Write, Debug, and Test Summary Programs
Phase IV - Run Data for Interim Report.

Pertinent aspects of each phase follows:

Phase I - Data Preparation

As the first step in processing the data forms, checks and corrections were made by hand as a preliminary to automated preparation steps. These manual steps included checks of program ID numbers, and logical completion of significant items.

The program for transferring data from card to disk, as well as the program to produce the formatted dump, had been written, tested and debugged prior to the implementation of Phase I. An instruction manual was developed for handling problems, e.g., treatment of non-responses. Due to the volume of the intake reports (some 53,000 records representing over 2 million bytes of information), Boone, Young & Associates decided that a large service bureau was necessary, and Multi-Phase Data Corporation was selected as the subcontractor for the keypunch/ verify tasks.

The Intake Forms were then sent to the subcontractor where they were double punched and verified. A temporary file was created on disk and a formatted dump* returned to Boone, Young & Associates.

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* Formatted Dump applies to the printout of card images in a manner which spaces or categorizes the output data.

Phase II - Creation of Permanent Intake Files

The formatted dump created from the temporary file in Phase I was carefully checked by the Boone, Young & Associates staff for inconsistencies. This will be illustrated by the consistency checks of the variable: status with regard to Head Start.

- Status with regard to Head Start (Pos 18 on disk or output field 0 4) should be equal to the number of participants who received/did not receive previous screening (Pos 22 on disk or Output Field 0 8).
- If the totals of these two fields are not equal an appropriate number of zeroes (no response) must be identified to account for the differences. A visual check of the column 0 4 or 0 8 is to be made to identify these non-responses. If totals for these fields are still not equal then a check for incorrect codes is to be made (0 4 or 0 8 ≠ 0, 1 or 2).

When incorrect codes were identified, the Head Start site was contacted and the correct responses ascertained. At this point, Boone, Young & Associates staff completed a new Intake Form, coding ID number and corrected information only. These forms were then sent to Multi-Phase Data Corp; where the data were keypunched and verified and overlayed on the old fields with the new correct data.

Once Boone, Young & Associates was satisfied that all corrections had been made for a batch, Multi-Phase Data was instructed to update the Permanent Master File with the new batch.

A print-out of the updated master was sent to Boone, Young & Associates where the new total was compared to a manual tape count (see Exhibit III).

Phase III - Write, Debug and Test Intake Forms

Boone, Young & Associates worked with an independent consultant to develop the program.

The program was written in RPG II and run on an IBM S/3 model with 15 Disk and 96K memory capacity. Because of the size of the program, it was broken up into 4 logical sections. There were no major problems in the writing and debugging of the program. The core required for running the program was approximately 51K .

Phase IV - Run Actual Data for Interim Report

This final phase produced the print-out of the information used in the analysis. The print-out was examined against several consistency checks. A sample print-out is included as Exhibit IV; the entry codes for transferring these and other data, e.g., those from the End-of-the Year reports, to the tables are outlined in Appendix D.

EXHIBIT III

DATA PROCESSING SYSTEM FLOW CHART

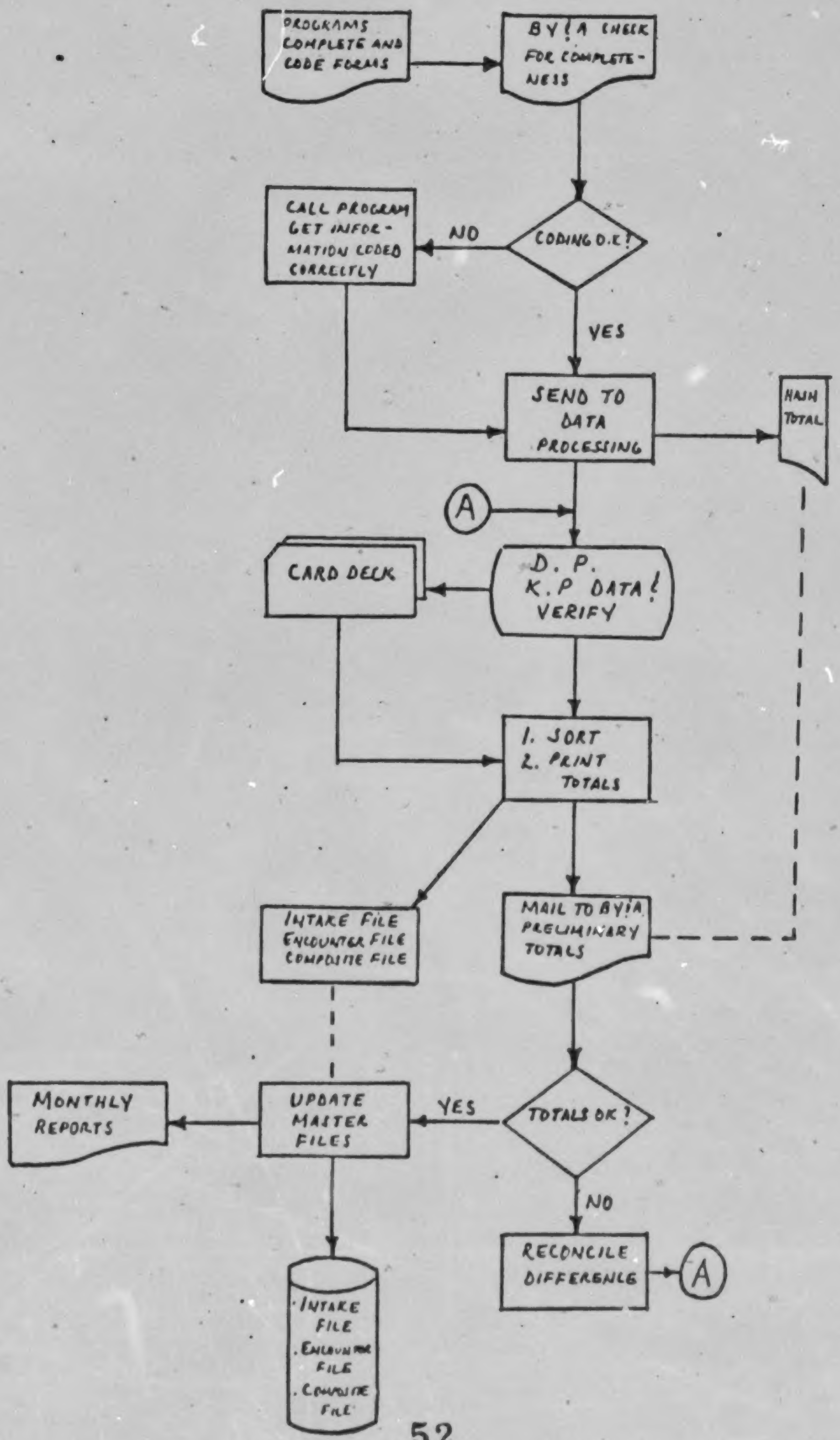
PROGRAMS COMPLETE AND CODE FORMS
BY!A CHECK FOR COMPLETENESS
CODING O.K!
NO
CALL PROGRAM GET INFORMATION CODED CORRECTLY
YES
SEND TO DATA PROCESSING
HASH TOTAL
A
CARD DECK
D. P. K.P DATA! VERIFY
1. SORT
2. PRINT TOTALS
INTAKE FILE ENCOUNTER FILE COMPOSITE FILE
MAIL TO BY!A PRELIMINARY TOTALS
TOTALS OK?
YES
UPDATE MASTER FILES
MONTHLY REPORTS
NO
RECONCILE DIFFERENCE
A
.INTAKE FILE
.ENCOUNTER FILE
.COMPOSITE FILE

EXHIBIT IV

SAMPLE PAGE OF COMPUTER PRINT-OUT FOR ANALYSIS

```
                TABLE  1   SECTION  E         TABLE  2   SECTION  B         TABLE  3   SECTION  E         TABLE  3   SECTION  E

                  01       02       03          01       02       03          01       02       03                   02       03

01-004-00         15       13        2          11        9        2           4        0        4          10        8        2
01-007-00        402      389       13         285      272       12         116       12      104         279      266       12
05-034-00        121      121        0          85       85        0          32       16       16          88       88        0
05-035-00        334      182      152         330      179      151           2        0        2         322      179      143
05-033-00        257      174       83         202      133       69          36        2       34         199      132       67
06-041-00        538      450       88         400      316       84         126        8      118         397      316       81
10-031-00          0        0        0           0        0        0           0        0        0           0        0        0
11-038-00        225      161       64         107       43       64         118        4      114         105       41       64
18-092-00        648      645        3         396      393        3         243        6      237         392      389        3
18-094-00        435      285      150         393      261      132          23       13       10         295      203       92
18-095-00        281      281        0         176      176        0         105        8       97         172      172        0
22-1[illegible]-00        471      455       16         295      287        8         166      155       11         293      285        8
22-120-00        233      231        2          45       44        1         187       14      173          45       44        1
22-124-00        731      685       45         148      110       38         575        0      575          98       60       38
29-143-00        124      119        5         124      119        5           0        0        0         124      117        5
2[illegible]-145-[illegible]          0        0        0           0        0        0           0        0        0           0        0        0
3[illegible]-[illegible]-00        190      160       30         115       98       17          62        0       62         115       98       17
3[illegible]-151-00        159      109       50          66       42       23          67       49       18          47       27       17
42-17[illegible]-00        177      132       45         118       87       31          45        8       37         117       86       31
42-176-00        213      116      101         194       94       97          24        5       19         190       90       97
[illegible]4-319-00        211      124       82          78       50       28          79       58       21          61       36       25
35-313-00         79       79        0          24       24        0          54        6       48          24       24        0
37-303-00        173      173        0          89       89        0          84       22       62          88       88        0
24-305-00       1092      946      146         203       97      104         836      668      168          74       65        9
REGION-01       3183     2229      954        2241     1572      669         637       36      601        2114     1465      623
REGION-02       5777     4029     1748        4306     2914     1392        1072      250      822        4053     2759     1297
REGION-03       3026     2625      401        1572     1194      378        1413      165     1248        1546     1176      370
REGION-04      10371     8385     1506        4036     2922     1098        5916      716     5200        3646     2569     1066
REGION-05       8007     6852     1155        5473     4389     1074        2399      461     1938        5086     4065     1012
REGION-06      13004    11998     1006        4247     3500      740        8441     2532     5909        3604     2992      606
REGION-07       4367     4199      168        2197     2055      142        2113     1052     1061        2048     1709      138
REGION-08       3053     2633      425        1574     1233      337        1390      210     1180        1510     1179      327
REGION-09        841      597      244         468      333      134         261      117      144         405      290      114
REGION-10       1903     1374      529        1240      812      428         556       68      488        1227      801      426
REGION-11       3328     2971      357        1187      983      201        1954      997      957         936      843       90
```

Problems Encountered in the First Year Evaluation

As in most evaluative studies, a variety of problems were encountered during the first year evaluation of the Head Start/ EPSDT Collaborative Effort. Important problems arose in two areas as discussed below:

- conceptualization
- process

A basic conceptual problem involved the definition of study objectives. The initial uncertainty regarding the program objectives of the collaborative effort described on Pages II-5 through II-12 complicated the defining of evaluation objectives. Additional complications stemmed from initial differences in perception within the OCD staff and between OCD staff and local programs regarding the program objectives. However, all agreed that the overall goal of the collaborative effort was to improve the health care of children by focusing on prevention, identification of illness, treatment, and linkage of the child and his family to ongoing systems of health care.

Primary goals of the OCD staff included:

a) an examination of the implementation of EPSDT, using Head Start as a vehicle;

b) an evaluation of the effectiveness of Head Start as an outreach mechanism for EPSDT;

c) the collection of information on the health care of children, including Head Start in general.

Also, there was concern with examining the policy issues of the collaborative effort in relation to future planning and program development for Head Start, including the problems and successes of making collaborative arrangements, the costs incurred in making such arrangements, and the possible reimbursements or savings to Head Start as a result of collaboration. Of interest, too, were the identification of health activities at the local level and the strengthening of the health components of the Head Start projects.

The evaluation team at Boone, Young & Associates felt that it was important to examine barriers that might prevent Head Start projects from making maximum use of Medicaid/EPSDT to pay for health services provided to Head Start children. Local Head Start programs had their own concerns and views of the collaboration, which varied with their interpretation of the guidelines and program requirements. Some projects saw the supplemental grant as a means of increasing staff time without assuming additional responsibility. Others viewed this as an opportunity to secure additonal health services for the children in their program and their siblings. Many were unaware of what was involved in the extensive evaluation of the effort, particularly since the guidelines had indicated that existing Head Start forms would be the basis for such a study.

The lack of explicit definition of evaluation objectives hampered the definition of study outcomes and, therefore, impacted upon the study processes. Initially, considerable time had to be spent with OCD staff in order to clarify the study objectives so that the development of forms and the collection of data could be undertaken with reasonable assurances that the policy needs of OCD would be met.

There was initial misunderstanding and hostility on the part of some local Head Start staff concerning the evaluation, resulting in delays which complicated the study process. When the supplemental grants to participate in the collaborative effort, were accepted by the projects, many of them were unaware of the requirements associated with the evaluation. Many project staff were skeptical, moreover, about the value of additional forms and found the study process burdensome. However, as the projects gained greater familiarity with the evaluation study process itself, many of these initial problems were resolved.

III. CHARACTERISTICS AND PREVIOUS CARE STATUS OF PARTICIPANTS IN HEAD START/EPSDT COLLABORATIVE EFFORT

Introduction

This section presents data (in the form of tables) on the collaborative effort as characterized by the participation of Head Start and non-Head Start children. Data are presented on Head Start enrollment status and Medicaid status, and on health care status in terms of previous receipt of screening and treatment services. The following tables are included in this section:

- Participation in Head Start/EPSDT Collaboration Effort (Aggregate) - Tables I & I-B
- Participation in Head Start/EPSDT Collaboration Effort (Selected Projects) - Table I-A
- Medicaid Eligibility of Participants in Head Start/EPSDT Collaboration Effort (Aggregate) - Table II
- Medicaid Certification of Participants in Head Start Collaboration Effort (Selected Projects) - Table II-A
- Medicaid Certification of Participants in Head Start/EPSDT Collaboration Effort (Aggregate) - Table III
- Medicaid Certification of Participants in Head Start Collaboration Effort (Selected Projects) - Table III-A
- Previous Health Care: Screening Status of Head Start Children Participating in Head Start/EPSDT Collaboration Effort (Aggregate) - Table IV
- Previous Health Care: Screening Status of Head Start Children Participating in Head Start/EPSDT Collaboration Effort (Selected Projects) - Table IV-A

- Previous Health Care: Health Status of Head Start Children Participating in Head Start/EPSDT Collaboration Effort (Aggregate) - Table V
- Previous Health Care: Health Status of Head Start Children Participating in Head Start/EPSDT Collaboration Effort (Selected Projects) - Table V-A
- Previous Health Care: Health Status of Non-Head Start Children Participating in Head Start/EPSDT Collaboration Effort (Aggregate) - Table VI
- Previous Health Care: Health Status of Non-Head Start Children Participating in Head Start/EPSDT Collaboration Effort (Selected Projects) - Table VI-A

This data will provide a basis for comparative analyses of EPSDT outcome data, when available, in addition to being of interest in their own right.

Entry instructions for all tables can be found in Appendix D.

A. PARTICIPATION IN THE COLLABORATIVE EFFORT (TABLES I, I-A & I-B*)

Tables I, I-A and I-B identify the projects' planned or anticipated participation, the actual number of children participating as reported on two different forms, and the level of turnover within the projects. The categories of participation are for Head Start and non-Head Start children and total number of children.

Definition of Terms

Planned Participation refers to the total number of children whom individual projects planned to serve as stated in their grant applications. These estimates are compared with the number of children reported actually served in the program year. It should be noted that these projections for services are gross estimates and are not based upon a survey of need by the projects.

Note that data on EPSDT target populations are not included in the table because these data, to be obtained by OCD from the Social and Rehabilitation Services Administration (SRS), have yet to be received. As a result, no analysis can be made of planned or actual participation compared to the target population.

Participation at Intake refers to the number of children for whom intake forms were submitted by the projects.

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*Table I-B represents the total number of projects submitting information re: Health Care Intake Form and End-of Year Status Report.

Cumulative Participation is the total number of children served by the project at any time during the year. This includes children who dropped from the program at any time during the program year; children for which no intake forms were completed; etc.

Participation at the End of the Program refers to the number of children remaining in the program at the end of the year; and, in the case of non-Head Start children, the information represents the number with whom the project has maintained contact. The difference between cumulative participation and participation at the end of the program reflects turnover, dropouts, and those leaving the program for various reasons.

Cumulative/Planned represents the number of children served at any time during the program year over the number of children the projects planned to serve. It is an indicator of how effective the projects were in achieving their service goals as defined by the number of children they planned to serve.

Head Start Children refers to all children enrolled in the Head Start program at the beginning of the collaborative effort and those who were admitted to the program during the year.

Non-Head Start Children refers to the siblings of Head Start children and non-siblings from the communities who were recruited to participate in the collaborative effort.

Other/Unknown refers to those children whose kinship to Head Start enrollees was unknown.

The data in Table I is grouped by national totals, selected project totals, and other project totals (national less selected projects) for 120 projects that submitted both Intake and End-of-the Year Status forms. Table I-A presents similiar information for eighteen selected projects that submitted both forms. Theoretically, intake and cumulative participation data should be equal; however, many projects (both selected and other) did not submit intake forms for each child participating in the collaborative effort. In such instances, cumulative participation was interpreted to include all children with whom the project had made contact.

B. ANALYSIS OF FINDINGS ON PARTICIPATION IN THE COLLABORATIVE EFFORT

1. The National Sample

a. Extent to which Planned Service Goals were Achieved

An examination of Table I provides a gross assessment of the extent to which the projects were successful in achieving their planned service goals. It should be noted that the projections for planned participation were only rough guesses.

First of all, projects varied in their interpretation regarding their responsibility to serve non-Head Start children. Secondly, there was some confusion as to whether the planned participation for Head Start children should reflect budgeted capacity or actual number of children enrolled. Moreover, some of the data extracted from the grant applications was incomplete, but, for purposes of this analysis, the data reflected in Table I represents the information as submitted to OCD.

Nationally, the Head Start projects provided services at sometime during the year to 74% of the planned service population. The selected projects showed a similar pattern as they reached 72% of their planned participation. There is some fluctuation in this pattern at the regional level. Regions I, VII, VIII and IX reported that actually more children participated than had been planned by reaching 106%, 118%, 141%, and 177%, respectively, of their projected service goals. Region II, on the other hand, reached only 34% of its planned participation. This fluctuation most likely reflects differences attributable to the way in which the projects developed their original projections for planned participation.

In comparing cumulative participation with intake participation, we find that Intake Forms were completed on 73% of those children who were served at any time during the year. The selected projects fared less well, as only 54% of the children served at any time during the program year had participated at intake. This may reflect sample bias. Again, there was fluctuation at the regional level. Regions II, IV, VI, and VII achieved a higher rate of congruence between cumulative and intake participation, 89%, 82%, 85% and 85%, respectively, than the national average. On the other hand, Region IX fell far below at 34%.

The difference between planned and actual participation was then examined relative to Head Start and non-Head Start children. The data indicates that, in general, the projects were much more successful in reaching their service goals for Head Start children than for non-Head Start children. Nationally, 108% of the planned service population was reached; while for the selected projects the figure was 111%. The incidence of Head Start projects serving even more Head Start children than had been planned holds true for all regions except Regions II, IV, IX and X. Region IX fell far below (45%) in serving its planned number of Head Start children.

The planned as compared to cumulative participation of non-Head Start children reveals a reverse pattern on a national basis. Only 39% of the non-Head Start population who had been projected for participation were actually served; the selected projects show a slightly higher rate at 47%. There is wide variation among the regions, again reflecting the manner in which the original projects were selected. Regions VII, VIII, IX and X reported services to many more non-Head Start children than had been planned. Regions II, III, and VI, however, fell below the national average at 19%, 25%, and 14%, respectively. Only Region I showed a relatively high congruence between planned and cumulative participation of non-Head Start children at 86%.

It should be noted that those regions with higher concentrations of urban populations--Regions I, II, and V--had planned to serve more non-Head Start than Head Start children. This estimate might be explained by a greater number of low-income Head Start eligible families in the area and the tendency of projects in urban areas to utilize available community resources and provide linkage of their families to these services. In regions where Head Start projects are the principal providers of services and few outside resources are available, the service estimates tended to be more modest.

b. Intake Participation of Non-Head Start Children

The breakdown on the intake form by sibling status afforded the opportunity to analyze intake participation based upon their familial relationship to Head Start enrolled children. Of the 38,417 children (Head Start and non-Head Start) who had participated at intake, only 15%, or 6,002 children, were non-Head Start, and 50% of these were siblings. For the selected projects, 11% of 5,182 children who participated at intake were not enrolled in the Head Start program.

Similarly, the various regions reflected this pattern, except for Regions I and III, where there was a greater evidence of non-sibling non-Head Start children served.

c. Level of Turnover

Table I also identifies the level of turnover the projects experienced in the total national enrollment of EPSDT service population. Cumulative participation was 52,189 whereas participation at the end of the program was 42,398, indicating a national turnover or drop-out of approximately 9,791 or 19% of the total served. This pattern holds true except for Regions IV and IX where the turnover rate was less than 10%. With regard to non-Head Start children a similar pattern holds. But in this case, the pattern probably indicates that many projects provided information on initial linkage but did not maintain or track the child through all aspects of screening, diagnosis and treatment.

2. The Selected Projects

Analysis of the selected projects (Table I-A) reveals patterns similar to the national and regional trends. These projects seemed to do somewhat better in achieving their planned service goals. Eight projects reported service to more children than planned. Lubbock, Kingston and Paterson fell short of their service goals, 43%, 42%, and 8%, respectively. Overall there was greater congruence among the selected projects between the numbers of children served cumulatively and those who participated at intake. However, in one instance, Leominster, only 15 intake forms were submitted, yet there was a report of 335 children having been served at sometime during the year. This project reported at the site visit that all Head Start children were receiving services comparable to EPSDT, and that, according to the grant application, the target area was restricted to one small rural community. The project was advised of the necessity for completing intake forms on all Head Start children served by EPSDT.

In reporting cumulative participation, (reference definition pg. III-4), several selected projects reported more service to non-Head Start children than planned. Leominster reported service to 71 children as compared to 50 non-Head Start children planned; Worcester 279 to 245; Medford 1,802 to no estimate. However, in all cases, comparable numbers of intake forms were not submitted. And in one case--Worcester--service to non-Head Start children consisted of simply informing the Head Start parent, at home interviews, that siblings were also eligible for EPSDT. This project did not complete intake forms or identify siblings of non-Head Start children who participated at intake, nor did it attempt to insure linkage or follow-up for the non-Head Start child. Medford reported serving 1,650 non-Head Start children but only submitted 45 intake forms for this group. The project helped link non-Head Start children to providers but did not complete intake forms on them.

C. DISCUSSION OF PARTICIPATION DATA

There are several possible explanations for the variations noted and for the phenomenon of national underservice or overestimating. Information extracted from grant applications, telephone inquiries, and site reports suggest the importance of the following:

- The projects did not receive clear instructions from their respective regional offices as to the priorities and objectives of the Collaborative Effort
- Many projects saw their function as providing public information rather than providing or arranging for direct services, which required additional manpower. Paterson, New Jersey is an example of a project with a large planned goal--nearly 5,000--which redefined its responsibility for service and submitted intake forms on only 152 children.
- The perception of the project staff prior experiences in preparing grant applications and proposals may have influenced the way they estimated for planned participation. However, the estimates do not seem to have been an important factor in funding for the collaborative effort. Some projects presented low outreach estimates of service (10-50 children, for example) and still received funding from OCD.
- Weaknesses in some of the grant applications is another factor. Many projects reported that they were prepared hastily. Some projects defined clearly how their estimates were obtained--from census information, welfare rates, etc.--and carefully detailed their outreach strategies, but many proposals gave no rationale for how the service estimate was determined. In many cases, it appeared that projects either misunderstood their roles or failed to understand what the planned service entailed.

As the tables reflect, the service estimates for Head Start children was more realistic than for the non-Head Start population. This pattern is logical because most projects simply reported their funding level. However, many projects had difficulty in making assessments of the number of non-Head Start children in need of service. Many proposals limited planned service to siblings. Others gave estimates of the number of children on welfare in the community but did not appear to have plans to serve or reach all these children.

Projects that recorded conservative estimates in their proposals appeared to come closer to meeting their goals as measured by the rate of cumulative/planned participation than projects that planned extensive participation. But the underestimaters should not necessarily be considered more effective in achieving their more limited goals.

D. CONCLUSIONS ON PARTICIPATION

1. During the first year of the collaborative effort, the Head Start demonstration projects were relatively successful in achieving the primary goal involving Head Start and non-Head Start children in EPSDT. Greater success was accorded the recruitment effort with Head Start children and their siblings because these children were easily accessible to the Head Start staff. Greater difficulty was experienced in reaching non-Head Start, non-sibling children possibly because of limited staff resources as well as the lack of clarity about the degree to which Head Start staff should be recruiting these children in the first instance.

2. The rate of turnover among the children served is comparable with other community programs serving pre-school children. Allowing for the probability that the age of the child and family circumstances may have limited participation over time. It can still be concluded that staff resources were not fully utilized in maintaining children in the program.

3. Projects were less successful in carrying out their responsibilities to complete intake forms on participating children. This lack of information on individual children may limit the scope of the evaluation study by reducing the number of children for whom an assessment can be made regarding the impact of EPSDT on their health care status.

E. RECOMMENDATIONS ON PARTICIPATION

1. Systematic planning should be initiated as the first step in the development of a community health service program which involves major outreach activities. The service staff need to know how many children can realistically be served, where they are located, and the kind of supportive services needed so that they can properly deploy their staff resources.

2. If the Head Start program is to expand its responsibility to include the non-Head Start child, then there must be a definition of services to be provided to this particular population. Expectation that existing staff can extend their responsibility to include an expanding number of children is counterproductive and can lead to a diminution of services to all the children, Head Start and non-Head Start.

3. Head Start programs as a matter of policy should be mandated to include the siblings of Head Start children in the ongoing assessment of the health service needs. This population is readily accessible to the Head Start staff and should be considered an integral part of the program participants. Siblings, for purposes of the Head Start programs, should not only include those children who have blood relationships to the Head Start child but also those who live within the household and are part of the family structure.

4. For future provision of services, Intake Forms should be developed that are easily administered to increase the likelihood that the Head Start staff will obtain the kind of health care history necessary in order to insure greater utilization of EPSDT services.

III-14
PARTICIPATION IN HEAD START/EPSDT COLLABORATION EFFORT BY AGGREGATED TOTALS

TABLE I	NATIONAL	SELECTED PROJECTS	ALL OTHER PROJECTS	REGIONS										
				I	II	III	IV	V	VI	VII	VIII	IX	X	IMPD
A. NUMBER OF STATES	42	12	42	3	2	4	8	6	5	4	6	3	1	4
B. NUMBER OF PROJECTS REPORTING*	119/198	18/30	101/168	10/16	16/25	5/10	25/40	12/25	20/27	5/12	13/20	3/12	10/11	7
C. EPSDT TARGET POPULATION	← Information To Be Provided By SRS →													
D. PLANNED PARTICIPATION: 1. Total	70,022	13,301	56,721	4,287	12,720	3,362	13,830	9,815	17,878	1,607	3,307	1,262	1,954	2,869
2. Head Start	36,112	5,109	31,003	1,817	3,565	1,792	7,843	3,895	11,095	1,551	2,008	1,248	1,298	1,050
3. Non-Head Start	33,910	8,192	25,718	2,470	9,155	1,570	5,987	5,920	6,783	56	1,299	14	656	1,819
E. PARTICIPATION AT INTAKE: 1. Total	38,417	5,182	33,235	2,784	3,927	2,279	7,844	4,682	11,262	1,535	2,216	241	1,647	778
2. Head Start	32,415	4,399	28,016	1,900	3,033	1,965	6,471	4,036	10,478	1,385	1,804	172	1,171	663
3. Non-Head Start	6,002	783	5,219	884	894	314	1,373	646	784	150	412	69	476	115
a) Siblings	3,050	606	2,444	235	557	73	634	404	444	100	292	63	248	22
b) Non-Siblings	2,653	141	2,512	564	333	230	727	204	261	29	104	2	199	88
c) Other	299	36	263	85	4	11	12	38	79	21	16	4	29	5
F. CUMULATIVE PARTICIPATION: 1. Total	52,189	9,561	42,628	4,566	4,368	2,810	9,420	7,196	13,119	1,893	4,674	694	3,449	1,887
2. Head Start	38,912	5,691	33,221	2,444	2,636	2,416	7,373	5,194	12,178	1,652	3,284	567	1,168	1,139
3. Non-Head Start	13,277	3,870	9,407	2,122	1,732	394	2,047	2,002	941	241	1,390	127	2,281	748
G. PARTICIPATION AT END OF PROGRAM: 1. Total	42,398	11,079	34,573	3,538	3,105	2,352	8,583	6,163	10,376	1,083	3,636	643	2,919	1,185
2. Head Start	32,120	7,604	27,270	2,077	2,143	1,961	6,661	4,484	9,748	853	2,747	516	930	903
3. Non-Head Start	10,278	3,475	7,303	1,461	962	391	1,922	1,679	628	230	889	127	1,989	282
H. %: PLANNED (D) / CUMULATIVE (F) 1. Total	74	72	75	106	34	84	68	73	73	118	141	55	177	66
2. Head Start	108	111	107	134	74	135	94	133	110	106	164	45	90	108
3. Non-Head Start	39	47	37	86	19	25	34	34	14	430	107	907	348	41

*Represents the total number of projects submitting both the Intake Form and the End-Of-Year Status Report over the universe of projects (for each respective category) participating in the Head Start/EPSDT Collaborative Effort

PARTICIPATION IN HEAD START/EPSDT COLLABORATION EFFORT BY SELECTED PROJECTS

TABLE I-A	NATIONAL TOTALS	MASS. (I)		NEW JERSEY (II)			MD. (III)	MISS.(IV)	TENN.(IV)	ILLINOIS (V)			OHIO (V)	
		Leominster	Worcester	Toms River	Paterson	Trenton	Baltimore	Cleveland	Kingston	Cook County	East St. Louis	Danville	Cincinnati	Dayton
NUMBER OF STATES	12													
NUMBER OF PROJECTS REPORTING*	18													
EPSDT TARGET POPULATION	← To Be Provided by SRS →													
PLANNED PARTICIPATION: 1. Total	13,301	250	650	380	4,930	440	613		628	1,199	1,079	352		
2. Head Start	5,109	200	405	180	180	240	461		140	589	390	260		
3. Non-Head Start	8,192	50	245	200	4,750	200	150		488	610	689	92		
PARTICIPATION AT INTAKE: 1. Total	5,182	15	402	121	334	257	538		225	648	435	281		
2. Head Start	4,399	13	389	121	182	174	450		161	645	285	281		
3. Non-Head Start	783	2	13	0	152	83	88		64	3	150	0		
a) Siblings	606	1	0	0	146	79	2		64	1	141	0		
b) Non-Siblings	141	1	0	0	6	2	86		0	0	8	0		
c) Other	36	0	13	0	0	2	0		0	2	1	0		
CUMULATIVE PARTICIPATION: 1. Total	9,561	335	743	169	400	384	625		261	906	613	282		
2. Head Start	5,691	264	464	129	190	282	488		167	499	458	282		
3. Non-Head Start	3,870	71	279	40	210	102	137		94	407	155	0		
PARTICIPATION AT END OF PROGRAM: 1. Total	7,825	270	407	163	351	345	576		227	855	539	246		
2. Head Start	4,850	210	407	123	165	243	439		136	448	384	246		
3. Non-Head Start	2,975	60	0	40	186	102	137		91	407	155	0		
%: PLANNED (D) / CUMULATIVE (F) 1. Total	72	134	114	44	8	87	102		42	76	57	80		
2. Head Start	111	132	115	72	106	118	105		119	85	117	108		
3. Non-Head Start	47	142	114	20	4	51	91		19	66	22	N/A		

*Represents the number of selected projects submitting both the Intake Form and the End-Of-Year Status Report.

NOTE: Blank columns reflect those selected projects not submitting both the Intake Form and the End-Of-Year Status Report. Thus, no information is provided for these projects.

PARTICIPATION IN HEAD START/EPSDT COLLABORATION EFFORT BY SELECTED PROJECTS

TABLE I-A (CONTINUED)	TEXAS (VI)			MISSOURI (VII)		MONTANA (VIII)			CALIFORNIA (IX)		OREGON (X)	
	Lubbock	Amarillo	Laredo (IMPD)	Appleton	Spring-field	Billings	Blackfeet (IMPD)	Fort Peck (IMPD)	El Centro	Fresno (IMPD)	Eugene	Medford
NUMBER OF STATES												
NUMBER OF PROJECTS REPORTING												
EPSDT TARGET POPULATION	To Be Provided By SRS											
PLANNED PARTICIPATION: 1. Total	270	1,120			440	146	197	362			105	140
2. Head Start	260	720			440	120	97	180			105	140
3. Non-Head Start	10	400			-0-	26	100	182			-0-	-0-
PARTICIPATION AT INTAKE: 1. Total	233	731			124	190	79	173			219	177
2. Head Start	231	686			119	160	79	173			118	132
3. Non-Head Start	2	45			5	30	0	0			101	45
a) Siblings	1	37			5	1	0	0			100	28
b) Non-Siblings	1	8			0	28	0	0			1	0
c) Other	0	0			0	1	0	0			0	17
CUMULATIVE PARTICIPATION: 1. Total	115	941			621	167	624	344			229	1,802
2. Head Start	112	896			515	147	174	344			128	152
3. Non-Head Start	3	45			106	20	450	0			101	1,650
PARTICIPATION AT END OF PROGRAM: 1. Total	95	794			531	129	114	324			190	1,669
2. Head Start	95	754			425	114	114	324			104	119
3. Non-Head Start	0	40			106	15	0	0			86	1,550
%: PLANNED (D) / CUMULATIVE (F) 1. Total	43	84			111	114	317	95			218	1,287
2. Head Start	43	124			117	123	179	191			122	109
3. Non-Head Start	30	11			N/A	77	450	N/A			N/A	N/A

PARTICIPATION IN HEAD START/EPSDT COLLABORATION EFFORT BY AGGREGATED TOTALS

TABLE I-B	NATIONAL	SELECTED PROJECTS	ALL OTHER PROJECTS	R E G I O N S										
				I	II	III	IV	V	VI	VII	VIII	IX	X	IMPD
NUMBER OF STATES	42	12	42	3	2	4	8	6	5	4	6	3	1	11
NUMBER OF PROJECTS REPORTING*	176/127 198	22/20 30	15[illegible]/107 [illegible]68	13/10 15	24/18 25	9/5 10	39/28 42	18/13 23	24/21 27	9/6 12	20/12 22	8/4 10	12/10 12	12/8 18
EPSDT TARGET POPULATION	←						To Be Provided By SRS							→
PLANNED PARTICIPATION:														
1. Total (N=198)**	128,372	19,303	109,069	8,112	17,594	11,070	23,321	24,745	18,675	6,080	4,741	3,791	2,822	7,421
2. Head Start	69,307	9,654	59,653	3,055	5,053	4,556	13,489	15,539	11,750	4,907	2,812	2,647	1,466	4,033
3. Non-Head Start	59,065	9,649	49,416	5,057	12,541	6,514	9,832	9,206	6,925	1,173	1,929	1,144	1,356	3,388
PARTICIPATION AT INTAKE:														
1. Total (N=176)**	53,557	7,115	46,442	3,183	5,777	3,026	10,391	8,007	13,004	4,367	3,058	841	1,903	3,328
2. Head Start	45,421	6,038	39,383	2,229	4,029	2,625	8,885	6,852	11,998	4,199	2,633	597	1,374	2,971
3. Non-Head Start	8,136	1,077	7,059	954	1,748	401	1,056	1,155	1,006	168	425	244	529	357
CUMULATIVE PARTICIPATION:														
1. Total (N=127)**	57,133	13,259	43,874	4,566	4,882	2,810	13,247	7,240	13,426	2,145	4,674	694	3,449	1,931
2. Head Start	43,008	8,870	34,138	2,444	3,046	2,416	10,535	5,230	12,431	1,887	3,284	567	1,168	1,175
3. Non-Head Start	14,125	4,389	9,736	2,122	1,836	394	2,712	2,010	995	258	1,390	127	2,281	756
PARTICIPATION AT END OF PROGRAM:														
1. Total (N=127)**	46,962	11,276	35,686	3,538	3,520	2,352	12,217	6,204	10,653	1,280	3,636	643	2,919	1,226
2. Head Start	35,863	7,784	28,079	2,077	2,480	1,961	9,630	4,518	9,971	1,033	2,747	516	930	937
3. Non-Head Start	11,099	3,492	7,607	1,461	1,040	391	2,587	1,686	682	247	889	127	1,989	289

* Represents the total number of projects submitting the Intake Form and the End-Of-Year Status Report over the universe of projects (for each respective category) participating in the Head Start/EPDST Effort, e.g. National = $\frac{176/127}{198}$ 176 = No. of projects submitting the Intake Form; 127 = No. of projects submitting the End-Of-Year, Status Form; and 198 = Universe (National) of projects participating in the Demonstration Effort.

** Represents the total number of projects reporting information in the respective categories.

A. MEDICAID STATUS OF PARTICIPANTS (TABLES II AND II-A)

Data on the Medicaid status of all participants--Head Start and non-Head Start--in the collborative effort is presented in Table II. Table II-A arrays the same characteristics for the selected projects. These tables identify the participants' Medicaid eligibility status, and examine whether Medicaid eligibility status changed throughout the collaboration year.

1. Definition of Terms

Cumulative Participation is the total number of children passing through the program during the year, as reported in Table I(F).

Eligibility for Medicaid at Intake identifies those children who are Medicaid eligible at intake, as reported on the intake form. Eligibility includes both children who are certified at intake, as well as those reported to be eligible but not yet certified. This latter category may include children felt to be eligible by the program but who were later determined to be ineligible and not certifiable.

This category is further delineated into the following:

Card Carriers - Are those children certified as eligible for Medicaid

Potentials - Are those children who may be eligible for Medicaid, but not yet certified

Other - Are those non-Head Start children identified as Card Carriers or Potentials, but whose status as a sibling or non-sibling cannot be determined.

Cumulative Number Eligible for Medicaid is taken from the programs' End of the Year Report Form, and reflects the total number of children eligible (certified and eligible but not yet certified) at any time during the program year.

Eligibility for Medicaid at the End of the Year identifies the total number of children currently certified or reported to be eligible but not enrolled at the end of the year as reported on the End of The Year Status Form.

Other Eligibility Status includes Head Start child who are either (a) not eligible for Medicaid; or (b) of unknown status at the time of intake.

End of the Year Other Eligibility Status refers to the projects' assessment of the number of children who fall into the "other" category at the end of the year. The category "other" is reported only for Head Start children. The demonstration projects accepted only those non-Head Start children who were Medicaid certified or Medicaid eligible children (the only children able to qualify for participation in EPSDT).

B. ANALYSIS OF FINDINGS ON MEDICAID ELIGIBILITY

1. The National Sample

a. Medicaid Status of Participating Children at Intake

Analysis of the tables reveal that, at the time of intake, of the 120 projects submitting both the Intake and End-of-Year Status Forms, 35% of the total number of children participating at any time during the program year were reported to be eligible for Medicaid. For the selected projects the rate was 33%, and all other projects reported 37%. This overall level of eligibility was increased during the program year, with 49% eligible at the end of the year. Only two regions, II and V, were above the national average.

Comparison of eligibility at intake for participating Head Start and non-Head Start children reveals that, nationwide, 37% of the Head Start children and 35% of the non-Head Start children were Medicaid eligible. With regard to Medicaid eligibility status at the end of the year, 37% of the Head Start children and 84% of the non-Head Start children were reported to be Medicaid eligible nationwide.

A comparison between participation at intake (Table I) and those children eligible for Medicaid at intake (Table II) reveals that 50% of the children who participated at intake were Medicaid eligible. For the selected projects this figure rose to 63%. There was regional variation relative to the percentage of children eligible for Medicaid as compared to total participation at intake. Regions I, II, V, VII, VIII, IX, and X reported averages higher than the national figure. Regions III, VI, and the IMPD projects were lower than the national average at 33%, 33%, and 37% respectively. With regard to the Head Start population nationally, 45% of all Head Start children was reported Medicaid eligible who participated at intake. For the selected projects, the percentage rose slightly higher to 48%.

b. Medicaid Eligibility/Participants on a Cumulative Basis

There is also variation at the regional level relative to the percentage of Head Start children eligible for Medicaid on a cumulative basis as compared to cumulative participation. Regions I, II, V, IX, and X report higher rates of Medicaid eligible children at 65%, 65%, 61%, 64%, and 67%, respectively, compared with the national rate of 41%.

Two regions and the IMPD projects reported low percentage of Medicaid eligible children relative to the total number of Head Start children participating, with the IMDP projects having the lowest rate at 3%.

This regional variability in both cumulative participation and intake may reflect several factors:

- There is a notable difference between the national poverty guidelines which establish the eligibility income levels for participation in Head Start and the State Medicaid eligibility standards.
- Many states only cover the categorically needy; while other states serve the medically needy as well. This variation in state Medicaid plans* may be reflected here.

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*In addition to the variations state to state, in some states eligibility determinations are made on the county level, and the income levels may differ between counties within one state.

- Some Head Start programs have recruiting policies to enroll high numbers of Medicaid eligibles; others accept any child within the poverty guidelines or the 10% addition into their programs.

c. Medicaid Status Cumulative/End of Year

A comparison of cumulative Medicaid eligibility and eligibility at the end of the year, 29,083 to 25,798 children, shows a decrease in the number of Medicaid eligibles at the end of the year. This reflects, in part, the turnover rate within the projects, as Medicaid eligibility is a highly unstable status. In fact, projects have reported that the Medicaid eligibility status of their children shifted several times during the course of the year. This change in eligibility status is a barrier for the effective delivery of services. For instance, a child may be eligible for EPSDT and referred for screening; by the time treatment services are needed, the child may be ineligible for care. It should be clear, however, that not all of the children believed to be eligible at intake are subsequently certified for Medicaid, thus their status may change over the year from eligible but not certified to non-eligible.

A comparison of Other Eligibility Status at Intake to the End of the Year for Head Start shows a change in the reporting of "other" eligibility status. The national totals at intake reflect a high number in the "unknown" category (85%) of all "other" and a lower number (15%) in the non-eligible category. The reverse holds true for the end of the year with higher totals in the non-eligible category (77%) than unknown (13%). At intake, 14,631 Head Start children were reported to have an unknown Medicaid eligibility status, as compared to 2,949 in the not eligible status. At the end of the year, there were 15,616 non-eligible children to 3,255 in the unknown status category. Nationally, and in every region, except in Region IV, there is a decrease in the number of children in an unknown eligibility status and a corresponding increase in the number of non-eligibles.

This pattern may reflect the fact that, at intake, a child's eligiblity may be unclear but as the year progresses eligibility determinations are made so that the status of the child is known to be either eligible or not eligible. The unknown category at intake might also reflect a project's procedures in determining eligibility at intake. Some projects accept the statement of the parent regarding his financial status and others compare income information to state guidelines and make a more thorough assessment.

d. Medicaid Eligibility of Non-Head Start Children

Nationally and in the selected projects, over 50% of the non-Head Start Medicaid eligible children at intake were siblings of Head Start. In both cases, the vast majority of the non-Head Start children were card carriers rather than potentially Medicaid eligible.

There is again wide variation at the regional level regarding the eligibility status of non-Head Start children at intake. Regions III, VI and VII report rates, 74%, 58%, and 54%, respectively, all of which are much higher than the national average of 35%. At the other end, Region X and the IMPD projects fall considerably below at 12% and 6% respectively.

In comparing the number of Head Start vs. non-Head Start children eligible for Medicaid at intake, Regions I and II report more non-Head Start than Head Start children eligible at intake. It is interesting to note the relatively few children whose familial relationship was unknown at intake. Of this latter group, all were card carriers.

2. The Selected Projects

Table II-A presents data on the Medicaid eligibility of children in the selected projects. There is wide variation among the projects regarding the percentage of Head Start children eligible compared to the total number participating. For instance, Eugene reported that 83% of the children participating were Medicaid eligible as contrasted with the Blackfeet Tribe which reported a low of 3%. For the selected projects as a whole, 37% of the total number of children participating were Medicaid eligible.

The projects reported a much greater number of Head Start children eligible for Medicaid at intake compared to non-Head Start children. Paterson and Billings had a greater proportion of participating Head Start children who were Medicaid eligible at intake. On the other hand, Amarillo and the two Indian tribes, Blackfeet and Fort Peck, had much lower percentages of Head Start children participating who were eligible for Medicaid at intake.

The projects served relatively few non-Head Start children who were eligible for Medicaid at intake. Several projects--Leominster, Worcester, Cook County, Springfield, and Medford--fell considerably below in this regard. Trenton and Eugene, however, had greater congruence between the number of non-Head Start children participating and those eligible at intake.

Similar to the national pattern, all projects that served non-Head Start children tended to serve siblings of Head Start enrollees.

Moreover, the vast majority of the non-Head Start children eligible at intake were card carriers. There is a noticeable exception in East St. Louis, where 40 out of the 132 non-Head Start children eligible for Medicaid at intake were deemed potentially eligible.

At the end of the year, several projects reported higher rates of eligibility for Head Start children compared to the overall average of 52%, with Paterson reporting 94% eligible, Trenton 79%, East St. Louis and Eugene 83%. Several projects reported particularly low rates: Kingston 31%, Springfield 24%, Blackfeet Tribe 28% and Amarillo, only 12%. This variability among projects may reflect the extent to which each took the responsibility to determine the Medicaid eligibility of Head Start children participating in the program over the year.

Cumulative eligibility is higher than Eligibility at Intake. This reflects that: (1) many projects reported cumulatively on children for whom no intake forms were submitted, and (2) the children's Medicaid status changed rapidly.

With respect to the category of Other Eligibility Status, the behavior of the selected projects is similar to the national pattern. At intake, 94% of the Head Start children in the "other" category were listed as having an unknown eligibility status with regard to Medicaid. At the end of the year, only 12% of the children were reported in the unknown category. However, there is project variability in this category. In ten projects, the number of unknowns was reduced to zero at the end of the year; and several other projects also had very low numbers of unknowns. Three projects reported large numbers of children whose Medicaid status was still unknown at the end of the year. Those reporting relatively little change in this area include two Indian tribes, Blackfeet and Fort Peck, with 114 children in an unknown status, 65% (92 unknown) and 50%, respectively. The third project, Amarillo, reported 10%, or 60 children still with unknown status as to Medicaid eligibility.

Many of the selected projects show a decreasing trend in the number of non-Head Start children eligibile for Medicaid at the end of the year as compared to total number of children eligible at any time during the year. This trend is not as prevalent for Head Start children. The decrease in the Head Start population is probably a reflection of program turnover. Moreover, some children initially believed to be eligible may have been later determined to be ineligible. The greater decrease in the case of non-Head Start children might reflect the failure of many projects to maintain contact with the children throughout the year and, therefore, the project had no information on their Medicaid status.

C. CONCLUSIONS ON MEDICAID ELIGIBILITY

1. Less than one half of the children participating nationally in the collaborative effort over the year were eligible for Medicaid. It would appear that the Head Start program had little appreciable impact in changing the Medicaid eligibility status of participating children-Head Start and non-Head Start. There is wide regional variation in this area which probably reflects the initiative of individual projects to determine the status of their participating children.

2. The rates for cumulative participation and Medicaid eligibility tend to be higher, probably reflecting the relative ease of use of the reporting instruments for this data.

3. The differences in eligibility standards for Medicaid and Head Start services may have affected the numbers of children who were found to be Medicaid eligible by the projects. Those states with relatively low Medicaid standards may have been unable to accept low-income children recruited by the Head Start projects for the collaborative effort.

4. The data suggests by the decrease in the number of Medicaid eligible children at the end of the year that, allowing for turnover rates, many children experience change in their Medicaid status over the year. Fluctuations in the Medicaid eligibility status of individual children may have detrimental impact upon the continuity of health care provided.

5. The marked change in the Other Eligibility Status for Head Start children from intake to the end of the year suggests a major effort by the projects to determine the Medicaid eligibility status of their participating children.

D. RECOMMENDATIONS ON MEDICAID ELIGIBILITY

1. Head Start health care personnel should have a thorough knowledge of the Medicaid eligibility standards in their state. This might aid in improving eligibility determination at intake and expedite the delivery of EPSDT services.

2. Medicaid/EPSDT eligibility determination should be made early in the program year so that Medicaid can pay for health services rendered, if appropriate, and the Head Start program can provide for follow-up.

3. Corollary to this, OCD should issue standardized procedures for assessing Medicaid eligibility by Head Start programs to increase the accuracy and appropriateness of referrals for Medicaid certification.

4. There should be periodic redeterminations, possibly every six months, of Medicaid eligibility status by the Head Start programs to maintain current, up-to-date information on the family's circumstances and minimize the probability that services will be cut off or delayed.

5. Head Start programs should establish working relationships with local EPSDT agencies to speed the determination and certification process of a referral child.

6. On a national level, OCD should review in-depth the eligibility levels problem that exists in many states that creates barriers to EPSDT services for low-income children, particularly Head Start enrollees.

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MEDICAID ELIGIBILITY OF PARTICIPANTS IN HEAD START/EPSDT COLLABORATION EFFORT BY AGGREGATED TOTALS

TABLE II						R	E	G	I	O	N	S		
	NATIONAL	SELECTED PROJECTS	ALL OTHER PROJECTS	I	II	III	IV	V	VI	VII	VIII	IX	X	IMPD
A. CHILDREN PARTICIPATING (CUMULATIVE) 1. Total	52,189	9,561	42,628	4,566	4,368	2,810	9,420	7,196	13,119	1,893	4,674	694	3,449	1,887
2. Head Start	38,912	5,691	33,221	2,444	2,636	2,416	7,373	5,194	12,178	1,652	3,284	567	1,168	1,139
3. Non-Head Start	13,277	3,870	9,407	2,122	1,732	394	2,047	2,002	941	241	1,390	127	2,281	748
B. ELIGIBLE FOR MEDICAID * AT INTAKE: 1. Total	19,408	3,241	16,167	1,954	3,007	1,095	3,140	3,169	3,757	897	1,135	126	1,128	290
2. Head Start	14,639	2,535	12,104	1,345	2,193	800	2,135	2,570	3,196	766	804	85	745	228
a) Card Carriers	13,448	2,403	11,045	1,279	2,093	785	1,911	2,335	2,739	721	765	85	735	197
b) Potentials	1,191	132	1,059	66	100	15	224	235	457	45	39	0	10	31
3. Non-Head Start	4,769	736	4,063	609	814	295	1,005	599	561	131	331	41	383	62
a) Siblings:														
1) Card Carriers	2,658	511	2,147	171	477	73	579	338	387	92	277	37	227	11
2) Potentials	98	50	48	14	25	0	2	47	8	0	1	0	1	1
b) Non Siblings:														
1) Card Carriers	1,684	112	1,572	329	273	210	392	197	86	28	35	1	133	37
2) Potentials	130	3	127	20	35	8	28	0	24	1	8	0	6	8
c) Other														
1) Card Carriers	199	30	169	75	4	4	[illegible]	17	56	10	10	1	16	3
2) Potentials	0	0	0	0	0	0	0	0	0	0	0	0	0	0
C. ELIGIBLE FOR MEDICAID * CUMULATIVE: 1. Total	29,083	6,805	22,278	3,705	3,456	1,238	4,097	5,168	4,192	900	2,774	492	3,061	1,089
2. Head Start	15,806	2,935	12,871	1,583	1,724	844	2,050	3,166	3,251	659	1,384	365	780	341
3. Non-Head Start	13,277	3,870	9,407	2,122	1,732	394	2,047	2,002	941	241	1,390	127	2,281	748
D. ELIGIBLE FOR MEDICAID * AT END OF YEAR: 1. Total	25,798	5,618	20,180	3,063	3,115	1,220	3,983	4,852	3,448	753	2,179	483	2,702	615
2. Head Start	14,646	2,687	11,959	1,552	1,581	829	1,930	3,025	2,818	618	1,247	356	630	297
3. Non-Head Start	11,152	2,931	8,221	1,511	1,534	391	1,993	1,827	630	135	932	127	2,072	318
OTHER ELIGIBILITY STATUS (HEAD START ONLY):														
E. AT INTAKE: 1. Total	17,580	1,836	15,744	537	797	1,154	4,295	1,448	7,238	610	993	85	423	431
2. Non-Eligible	2,947	124	2,825	29	142	111	445	183	1,862	51	106	2	18	71
3. Unknown	14,631	1,712	12,919	508	655	1,043	385	1,265	5,376	559	887	83	405	360
F. END OF YEAR: 1. Total	18,871	3,960	14,911	525	626	1,138	6,386	1,485	6,577	760	914	160	300	702
2. Non-Eligible	15,616	3,682	11,934	524	471	1,058	5,759	1,426	4,472	746	758	160	242	490
3. Unknown	3,255	278	2,977	1	155	80	627	99	2,105	14	156	0	58	212
G. % (Head Start Only): ELIGIBLE (C2) PARTICIPATING (A2)	41	52	39	65	65	35	29	61	27	40	42	64	67	30

NOTE:

1.) Card Carriers represent those children who are certified as eligible for Medicaid.

2.) Potentials represent those children who may be eligible for Medicaid, but who are not yet certified.

3.) Other represents those Non-Head Start children who have been identified as Card Carriers or Potentials, but whose status as a Sibling or Non-Sibling cannot be determined.

* Represents those children who are Medicaid eligible (Card Carriers) and potentially eligible (Potentials).

MEDICAID ELIGIBILITY OF PARTICIPANTS IN HEAD START/EPSDT COLLABORATION EFFORT BY SELECTED PROJECTS

TABLE II-A

	TOTAL SELECTED PROJECTS	MASS. (I)		NEW JERSEY (II)			MD. (III)	MISS. (IV)	TENN. (IV)	ILLINOIS (V)			OHIO (V)	
		Leominster	Worcester	Toms River	Paterson	Trenton	Baltimore	Cleveland	Kingston	Cook County	East St. Louis	Danville	[illegible]	Dayton
A. CHILDREN PARTICIPATING (CUMULATIVE) 1. Total	9,561	335	743	169	409	394	623		281	906	613	282		
2. Head Start	5,691	264	464	129	190	282	488		167	499	458	282		
3. Non-Head Start	3,870	71	279	40	210	102	137		94	407	155	0		
B. ELIGIBLE FOR MEDICAID* AT INTAKE: 1. Total	3,241	11	284	88	330	202	400		107	396	393	176		
2. Head Start	2,535	9	272	88	179	133	316		43	393	261	176		
a) Card Carriers	2,403	8	266	88	179	132	316		41	389	203	172		
b) Potentials	132	1	6	0	0	1	0		2	4	58	4		
3. Non-Head Start	706	2	12	0	151	69	84		64	3	132	0		
a) Siblings														
1) Card Carriers	511	1	0	0	137	64	2		64	1	85	0		
2) Potentials	50	0	0	0	8	2	0		0	0	40	0		
b) Non-Sibling														
1) Card Carriers	112	1	0	0	6	1	79		0	0	6	0		
2) Potentials	3	0	0	0	0	0	3		0	0	0	0		
c) Other														
1) Card Carriers	30	0	12	0	0	2	0		0	2	1	0		
2) Potentials	10	0	0	0	0	0	0		0	0	0	0		
C. ELIGIBLE FOR MEDICAID* CUMULATIVE: 1. Total	6,805	230	581	122	389	324	472		145	712	534	170		
2. Head Start	2,935	159	302	82	179	222	335		51	305	379	170		
3. Non-Head Start	3,870	71	279	40	210	102	137		94	407	155	0		
D. ELIGIBLE FOR MEDICAID* AT END OF YEAR: 1. Total	5,618	200	297	106	354	324	472		145	708	534	141		
2. Head Start	2,687	159	297	81	144	222	335		51	301	379	141		
3. Non-Head Start	2,931	41	0	25	210	102	137		94	407	155	0		
OTHER ELIGIBILITY STATUS (HEAD START ONLY):	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////	//////////
E. AT INTAKE: 1. Total	1,836	4	116	32	2	36	126		118	243	23	105		
2. Non-Eligible	124	0	12	16	0	2	8		4	6	13	8		
3. Unknown	1,712	4	104	16	2	34	118		114	237	10	97		
F. END OF YEAR: 1. Total	2,275	51	110	42	21	21	104		97	147	5	105		
2. Non-Eligible	1,997	51	110	40	21	21	104		96	146	5	104		
3. Unknown	278	0	0	2	0	0	0		1	1	0	1		
G. % (Head Start Only): ELIGIBLE (C2) / PARTICIPATING (A2)	52	60	65	64	94	79	69		31	61	83	60		

NOTE:

1.) Card Carriers represent those children who are certified as eligible for Medicaid.

2.) Potentials represent those children who may be eligible for Medicaid, but who are not yet certified.

3.) Other represents those Non-Head Start children who have been identified as Card Carriers or Potentials, but whose status as a Sibling or Non-Sibling cannot be determined.

* Represents those children who are Medicaid eligible (Card Carriers) and potentially eligible (Potentials).

– columns reflect those projects which have not submitted both the Intake Form and the End-Of-Year Status Report. Thus, no information is provided for these projects.

MEDICAID ELIGIBILITY OF PARTICIPANTS IN HEAD START/EPSDT COLLABORATION EFFORT BY SELECTED PROJECTS

TABLE II-A (CONTINUED)	TEXAS (VI)			MISSOURI (VII)		MONTANA (VIII)			CALIFORNIA (IX)		OREGON (X)			
	Lubbock	Amarillo	Laredo (IMPD)	Appleton	Springfield	Billings	Blackfeet (IHPD)	Fort Peck (IHPD)	El Centro	Fresno (IMPD)	Eugene	Medford		
A. CHILDREN PARTICIPATING (CUMULATIVE) 1. Total	115	941			621	167	624	344			229	1,802		
2. Head Start	112	896			515	147	174	344			128	152		
3. Non-Head Start	3	45			106	20	450	0			101	1,650		
B. ELIGIBLE FOR MEDICAID • AT INTAKE: 1. Total	45	148			124	115	24	89			191	118		
2. Head Start	44	110			119	98	24	89			94	87		
a) Card Carriers	44	60			119	98	24	88			90	86		
b) Potentials	0	50			0	0	0	1			4	1		
3. Non-Head Start	1	38			5	17	0	0			97	31		
a) Siblings														
1) Card Carriers	0	37			5	1	0	0			96	18		
2) Potentials	0	0			0	0	0	0			0	0		
b) Non-Siblings														
1) Card Carriers	1	1			0	16	0	0			1	0		
2) Potentials	0	0			0	0	0	0			0	0		
c) Other														
1) Card Carriers	0	0			0	0	0	0			0	13		
2) Potentials	0	0			0	0	0	0			0	2		
C. ELIGIBLE FOR MEDICAID • CUMULATIVE: 1. Total	48	156			231	103	498	140			207	1,743		
2. Head Start	45	111			125	83	48	140			106	93		
3. Non-Head Start	3	45			106	20	450	0			101	1,650		
D. ELIGIBLE FOR MEDICAID • AT END OF YEAR: 1. Total	17	70			125	82	71	140			115	1,717		
2. Head Start	16	44			125	62	41	140			82	67		
3. Non-Head Start	1	26			0	20	30	0			33	1,650		
OTHER ELIGIBILITY STATUS (HEAD START ONLY):	//////	//////	//////	//////	//////	//////	//////	//////	//////	//////	//////	//////	//////	//////
E. AT INTAKE: 1. Total	187	575			0	62	54	84			24	45		
2. Non-Eligible	14	0			0	0	6	22			5	8		
3. Unknown	173	575			0	62	48	62			19	37		
F. END OF YEAR: 1. Total	79	710			300	52	173	184			22	52		
2. Non-Eligible	79	650			300	52	59	92			15	52		
3. Unknown	0	60			0	0	114	92			7	0		
G. % (Head Start Only): ELIGIBLE (C2) / PARTICIPATING (A2)	40	12			24	56	28	41			83	61		

A. MEDICAID CERTIFICATION STATUS OF PARTICIPANTS (TABLES III AND III-A)

Medicaid status may be analyzed through an examination of the certification patterns of those children categorized as Medicaid eligible in previous tables. Certification refers to the status of each child determined to be eligible for Medicaid by the state agency. Certification differs from eligibility in that it refers only to those children actually enrolled in Medicaid but not those who are potentially eligible though not yet certified. This table describes the extent to which those children believed to be eligible were actually certified.

Definition of Terms

Cumulative Participation is derived from Table II, and reflect the total number participating throughout the year.

Medicaid Eligibility (Cumulative) refers to the total number of children eligible for Medicaid or believed to be eligible at any point in the year.

Certified Prior to the Program is derived from the intake forms and describes the number of children who were certified for Medicaid prior to intake into the program.

Cumulative Certification refers to the total number of children actually certified for Medicaid at any time during the year, as reported on the End of the Year Form.

Certified at the End of the Year records the total number certified at the end of the year.

B. ANALYSIS OF FINDINGS ON CERTIFICATION

1. The National Sample

a. Medicaid Eligibility/Certification on a Cumulative Basis

Examination of eligibility and certification as reported on the End-Of-Year Status Form reveals that a total of 29,083 children, Head Start and non-Head Start, were found to be Medicaid eligible during the program year. Of these 25,737 or 88%, were actually certified at any time during the program year. Of the total number of Medicaid eligible children in the selected projects, 90% were certified at some point during the year while 88% of the eligible children in the other projects were certified.

Nationally, 93% of the Medicaid eligible Head Start children served during the year were certified at some point during this period; 96% of the Medicaid eligible children in the selected projects, and 92% of such children in all other projects were certified. For non-Head Start children as a whole, 83% of those Medicaid eligible served during the year were certified, 85% in the selected projects, and 82% in the other projects.

At the regional level, the percentage of Medicaid eligible children certified throughout the year ranged from 50% to 100%. For instance, Regions V, VII, and IX reported that all children found to be eligible were certified. On the other hand, the IMPD projects reported that only one-half of their Medicaid eligible children fell in this category. The rest of the regions reported percentages 77% and above.

There is also some variation with respect to the relation of certification to eligibility in the Head Start and non-Head Start populations. In Regions VII and IX, all children, regardless of Head Start status, who were Medicaid eligible were certified. Several regions--I, II, VIII, X and the IMPD projects--reported higher ratios of cumulative certified/cumulative eligibles for Head Start children than the non-Head Start population. Those remaining reported that they had, in fact, more non-Head Start Medicaid eligible certified than Head Start.

This variation may reflect either differences among projects in their eligibility screening and certification procedure, or their knowledge of the state Medicaid eligibility requirements. Some projects may have reported as Medicaid eligible only those children certified at the time of intake; whereas others might have reported all uncertified children believed to be eligible but later found to be ineligible. Additionally, the idiosyncracies of certification procedures hamper and complicate certification and may have discouraged potentially eligible children from applying for Medicaid.

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*IMPDprojects receive free health care services through Indian Health Services regardless of Medicaid status or othe eligibility criteria. All Indians (on reservations) receive free medical attention.

Moreover, tracking procedures and knowledge of individual children's circumstances are better for Head Start than non-Head Start populations.

An analysis of Certification and Total Participation data shows that 49% of all children participating in the collaboration were Medicaid certified. At the regional level, the percentage of cumulative certification to total participation ranged from 24% (Region VI) to 77% (Region X).

With respect to the ratio, cumulative certification/cumulative participation, different patterns were found for Head Start and non-Head Start children. The national figure for the Head Start population is 38%, ranging from 19% in Region VI to 68% in Region V. This may reflect differences in enrollment patterns, as discussed in the previous section. The portion of non-Head Start participants who were Medicaid certified at sometime during the year was 83%. Most regions report a relatively high percentage of certified non-Head Start children, ranging from 41% to 100%.

Another point of interest is the comparison of Head Start children believed to be eligible with a percentage determined to be certified: 41% of all Head Start children participating cumulatively were eligible compared with 38% who were determined to be certified. This means that only 3% of those believed to be eligible were later determined not to be eligible.

b. Medicaid Certification Status Prior to Participation in the Collaborative Effort

A comparison of Medicaid certification status prior to intake into the program and Medicaid eligibility at intake reveals that 92% of children deemed eligible at intake had been certified prior to the program (91% in the selected projects and 92% in all other projects). This relatively high incidence of prior certification was found in all regions. With regard to Head Start children, 97% of all those eligible at intake had been certified prior to entering the program. This pattern also holds across all regions.

c. Medicaid Certification Status at the End of the Year

Of all children remaining in the program or in contact with the program at the end of the year, 44% were Medicaid certified. There is a high degree of variation across regions ranging from a certification rate of 19% in Region VI to 72% in Region X. For the Head Start population, the range was from 16% to 62%. This variation might reflect differential regional service patterns regarding the proportion of Medicaid eligible children served by the Head Start projects.

Of the non-Head Start children certified prior to the program, over 50% (2,658 out of 4,541) were siblings of Head Start enrollees.

For the selected projects, the proportion of non-Head Start children who were siblings of Head Start enrollees increases to 71%. Notable differences exist in Regions I, III and IMPD projects where the greater proportion of non-Head Start children consisted of non-siblings.

2. The Selected Projects

For the selected projects, the ratio of children cumulatively certified to the number cumulatively participating varied more than the national pattern, with a range from 15% to 91%.

The selected projects as a whole reported that 90% of all children believed to be eligible cumulatively for Medicaid were certified at sometime during the year. Ten projects reported that 100% of the Medicaid eligible Head Start children in their projects were certified for Medicaid. Most projects reported high rates of certified/eligible with the exception of Fort Peck. Slightly lower rates are reported for non-Head Start children, with the overall percentage for the selected projects at 85%. The lowest rates reported were the Blackfeet Tribe with 7% and Lubbock with 33%.

C. CONCLUSIONS ON MEDICAID CERTIFICATION

1. Head Start projects were reasonably successful in reaching and screening children for Medicaid eligibility, particularly in the case of non-Head Start children.

2. It should be noted that the projects' outreach techniques to non-Head Start children, in many cases, emphasized the recruitment of siblings of Head Start enrollees; siblings of children already certified, rather than siblings in Head Start families believed to be eligible but not yet centified.

3. It is also possible that some projects waited until ceritfication was secured before selection. Those regions which reported lower non-Head Start certification rates may have been more effective in outreach

4. Based upon observations made on the on-site visits the parent involvement component was generally useful in providing for outreach, screening, and establishing Medicaid eligibility, particularly with the siblings of Head Start enrollees.

D. RECOMMENDATIONS ON MEDICAID CERTIFICATION

1. Head Start projects should be provided assistance in placing greater emphasis on developing outreach techniques that can bring more potentially eligible but not necessarily already certified children into EPSDT. In order to fully implement such a strategy, however, available staff resources must be considered

2. Because of the demonstrated success in reaching siblings, the Parent Involvement Component in the Head Start program should be given even greater stress in its role to ensure that community resources are made available to all members of Head Start families.

MEDICAID CERTIFICATION OF PARTICIPANTS IN THE HEAD/EPSDT COLLABORATION EFFORT BY AGGREGATED TOTALS

						R	E	G	I	O	N	S		
TABLE III	NATIONAL	SELECTED PROJECTS	ALL OTHER PROJECTS	[illegible]	II	III	IV	V	VI	VII	VIII	IX	X	IMPD
A. CHILDREN PARTICIPATING (CUMULATIVE): 1. Total	52,189	9,561	42,628	4,566	4,368	2,810	9,420	7,196	13,119	1,893	4,676	694	3,449	1,887
2. Head Start	38,912	5,691	33,221	2,4[illegible]	2,636	2,416	7,373	5,194	12,178	1,652	3,284	567	1,168	1,139
3. Non-Head Start	13,277	3,870	9,407	2,122	1,732	394	2,047	2,002	941	241	1,390	127	2,281	748
B. MEDICAID-ELIGIBLE* (CUMULATIVE): 1. Total	29,083	6,805	22,278	3,705	3,456	1,238	4,097	5,168	4,192	900	2,774	492	3,061	1,089
2. Head Start	15,8[illegible]	2,935	12,871	1,583	1,724	844	2,050	3,166	3,251	659	1,384	365	780	341
3. Non-Head Start	13,277	3,870	9,407	2,122	1,732	394	2,047	2,002	941	241	1,390	127	2,281	748
C. CERTIFIED PRIOR TO PROGRAM: 1. Total	17,989	3,056	14,933	1,85[illegible]	2,847	1,072	2,886	2,887	3,268	851	1,087	127	1,111	249
2. Head Start	13,448	2,403	11,045	1,279	2,093	785	1,911	2,335	2,739	721	765	[illegible]	735	197
3. Non-Head Start	4,541	653	3,888	575	754	287	975	552	529	130	322	41	376	52
a) Siblings	2,658	511	2,147	171	477	73	579	338	387	92	277	37	277	13
b) Non-Siblings	1,684	112	1,572	329	273	210	392	197	86	28	35	1	133	37
c) Other**	199	30	169	75	4	6	4	17	56	10	10	3	16	2
D. CUMULATIVE CERTIFICATION: 1. Total	25,737	6,136	19,601	3,315	2,744	1,179	3,870	5,168	3,249	900	2,148	492	2,672	551
2. Head Start	14,684	2,828	11,856	1,573	1,697	788	1,932	3,378	2,416	659	1,199	365	677	239
3. Non-Head Start	11,053	3,308	7,745	1,742	1,047	391	1,938	1,790	833	241	949	127	1,995	312
E. CERTIFIED AT END OF YEAR: 1. Total	23,335	5,546	17,789	3,003	2,564	1,158	3,704	4,627	2,611	843	1,841	483	2,501	481
2. Head Start	13,157	2,568	10,589	1,542	1,554	767	1,779	2,948	1,983	613	1,066	356	549	199
3. Non-Head Start	10,178	2,978	7,200	1,461	1,010	391	1,925	1,679	628	230	775	127	1,952	282
F. %: CERTIFIED (D) / PARTICIPANTS (A) 1. Total	49	64	46	72	6[illegible]	41	41	72	24	48	45	70	77	29
2. Head Start	38	50	35	64	64	32	26	65	19	40	36	64	57	20
3. Non-Head Start	83	85	82	82	60	99	95	89	88	100	68	100	87	41
G. %: CERTIFIED (D) / ELIGIBLE (B) 1. Total	88	90	88	89	79	95	94	100	77	100	77	100	87	50
2. Head Start	83	96	92	99	9[illegible]	93	94		74	100	8[illegible]	100	86	70
3. Non-Head Start	83	85	82	82	58	99	95	89	88	100	68	100	87	41

*Represents those children who are Medicaid card carriers and those who are potentially eligible for Medicaid.

** Represents those Non-Head Start known to be certified prior to the program but whose status as a sibling or non-sibling cannot be determined.

MEDICAID CERTIFICATION OF PARTICIPANTS IN THE HEAD START/EPSDT COLLABORATION EFFORT BY SELECTED PROJECTS

TABLE III-A

	TOTAL SELECTED PROJECTS	MASS. (I)		NEW JERSEY (II)			MD. (III)	MISS. (IV)	TENN. (IV)	ILLINOIS (V)			OHIO (V)	
		Leominster	Worcester	Toms River	Paterson	Trenton	Baltimore	Cleveland	Kingston	Cook County	East St. Louis	Danville	Cincinnati	Dayton
A. CHILDREN PARTICIPATING (CUMULATIVE): 1. Total	9,561	335	743	169	400	384	625		261	906	613	282		
2. Head Start	5,691	264	464	129	190	282	488		167	499	458	282		
3. Non-Head Start	3,870	71	279	40	210	102	137		94	407	155	0		
B. MEDICAID-ELIGIBLE * (CUMULATIVE): 1. Total	6,805	230	581	122	389	324	472		145	712	534	170		
2. Head Start	2,935	159	302	82	179	222	335		51	305	379	170		
3. Non-Head Start	3,870	71	279	40	210	102	137		94	407	155	0		
C. CERTIFIED PRIOR TO PROGRAM: 1. Total	3,056	10	278	88	322	199	397		105	392	295	172		
2. Head Start	2,403	8	266	88	179	132	316		41	389	203	172		
3. Non-Head Start	653	2	12	0	143	67	81		64	3	92	0		
a) Siblings	511	1	0	0	137	64	2		64	1	85	0		
b) Non-Siblings	112	1	[illegible]	0	6	1	79		0	0	6	0		
c) Other **	30	0	12	0	0	2	0		0	2	1	0		
D. CUMULATIVE CERTIFICATION: 1. Total	6,136	219	579	121	365	324	469		141	712	534	169		
2. Head Start	2,828	159	300	81	179	222	332		47	305	379	169		
3. Non-Head Start	3,308	60	279	40	186	102	137		94	407	155	0		
E. CERTIFIED AT END OF YEAR: 1. Total	5,546	219	295	120	330	324	469		129	708	534	140		
2. Head Start	2,568	159	295	80	144	222	332		35	301	379	140		
3. Non-Head Start	2,978	60	0	40	186	102	137		94	407	155	0		
F. %: CERTIFIED (D) / PARTICIPANTS (A) 1. Total	64	65	78	72	91	84	75		55	79	87	60		
2. Head Start	50	60	65	48	45	79	68		28	61	83	60		
3. Non-Head Start	85	85	100	100	89	100	100		100	100	100	0		
G. %: CERTIFIED (D) / ELIGIBLE (B) 1. Total	90	95	99	99	94	100	99		99	100	100	99		
2. Head Start	96	100	99	99	100	100	99		92	100	100	99		
3. Non-Head Start	85	[illegible]	100	100	89	100	100		100	100	100			

* Represents those children who are Medicaid card carriers and those who are potentially eligible for Medicaid.

** Represents those Non-Head Start known to be certified prior to the program but whose status as a sibling or non-sibling cannot be determined.

NOTE: Blank columns reflect those selected projects not submitting both the Intake Form and the End-Of-Year Status Report. Thus, no information is provided for these projects

MEDICAID CERTIFICATION OF PARTICIPANTS IN HEAD START/EPSDT COLLABORATION BY SELECTED PROJECTS

TABLE III-A (CONTINUED)	TEXAS (VI)			MISSOURI (VII)		MONTANA (V III)			CALIFORNIA (IX)		OREGON (X)	
	Lubbock	Amarillo	Laredo (IMPD)	Appleton	Spring-field	Billings	Blackfeet (IMPD)	Fort Peck (IMPD)	El Centro	Fresno (IMPD)	Eugene	Medford
A. CHILDREN PARTICIPATING (CUMULATIVE): 1. Total	115	941			621	167	624	344			229	1,802
2. Head Start	112	896			515	147	174	344			128	152
3. Non-Head Start	3	45			106	20	450	0			101	1,650
B. MEDICAID-ELIGIBLE * (CUMULATIVE): 1. Total	48	156			231	103	498	140			207	1,743
2. Head Start	45	111			125	83	48	140			106	93
3. Non-Head Start	3	45			106	20	450	0			101	1,650
CERTIFIED PRIOR TO PROGRAM 1. Total	45	98			124	115	24	88			187	117
2. Head Start	44	60			119	98	24	88			90	86
3. Non-Head Start	1	38			5	17	0	0			97	31
a) Siblings	0	37			5	1	0	0			96	18
b) Non-Siblings	1	1			0	16	0	0			1	0
c) Other **	0	0			0	0	0	0			0	13
D. CUMULATIVE CERTIFICATION: 1. Total	46	156			226	98	78	52			204	1,643
2. Head Start	45	111			120	83	48	52			103	93
3. Non-Head Start	1	45			106	15	30	0			101	1,550
E. CERTIFIED AT END OF YEAR: 1. Total	16	84			226	77	41	52			165	1,617
2. Head Start	16	44			120	62	41	52			79	67
3. Non-Head Start	0	40			106	15	0	0			86	1,550
F. %: CERTIFIED (D) / PARTICIPANTS (A) 1. Total	56	17			36	59	8	15			89	91
2. Head Start	41	12			23	56	28	15			80	61
3. Non-Head Start	33	100			100	75	7	N/A			100	94
G. %: CERTIFIED (D) / ELIGIBLE (B) 1. Total	96	100			98	95	16	37			99	94
2. Head Start	100	100			96	100	100	37			97	100
3. Non-Head Start	33	100			100	75	7	N/A			100	94

A. PREVIOUS HEALTH CARE: SCREENING OF HEAD START PARTICIPANTS (TABLE IV AND IV-A)

Data is presented in the next few related tables to describe the previous health care, both screening and treatment, that had been received by participating Head Start and non-Head Start children, prior to their entry into the collaborative effort. This information will serve as the baseline for comparative analysis in the final report to determine the impact of the collaborative effort as shown by the health care received as a result of this effort.

Tables IV and IV-A show the health screening status of Head Start children prior to their entry into the EPSDT Collaborative Effort. Data presented in these tables was collected from intake forms completed by the projects, which requested information on screening obtained within the year prior to entry. Information on the intake form was collected from parents and, in some instances, from providers. It should be noted that the data reported is directly related to the parental ability to recall the child's health care history.

The intake data was collected within two time frames: screening and treatment information refer to the 12 months prior to enrollment; Medicaid certification status refers to the time of entry into the program. The total number of Head Start children participating as categorized by prior enrollment status and Medicaid certification, do not necessarily add in all instances because of variations in response rates which are not shown in the tables. The totals included are broken down by children previously enrolled/not previously enrolled and those Medicaid certified/not Medicaid certified.

Medicaid certification and prior enrollment in Head Start are reflected in the following three categories:

(A) Medicaid and enrollment status of children at intake

(B) Medicaid and enrollment status data of children who received prior health screening

(C) The proportion of children screened to those participating at intake.

1. Definition of Terms

Medicaid certification status is presented by three sub-categories within each of the major parts of the tables:

- Medicaid Certified (1) - indicates those children who actually have been certified by a responsible agency as eligible for Medicaid.

- Not-Medicaid Certified (2) - are those children who are believed by the reporting projects to be eligible for Medicaid but not yet certified.
- Other (3) - combines those children ineligible for Medicaid and those children whose Medicaid status was unknown to the reporting projects at the point of enrollment.

Previous enrollment status of the child refers to prior participation in Head Start. The definition of screening ranges from receipt of one screening test to a full screening package as set forth in the EPSDT regulations.

B. ANALYSIS OF FINDINGS ON PREVIOUS HEALTH CARE OF HEAD START PARTICIPANTS

1. The National Sample

On the national level, 22% of the Head Start children had been enrolled previously in Head Start. The largest number of children carried over from the previous year occurred in the IMPD projects where over one out of three Head Start children had been previously enrolled. Carryover of children was less prevalent in Region IX, where less than 10% of the children had been enrolled in Head Start previously.

The status of prior enrollment in Head Start is important in reviewing screening services received prior to the collaborative effort, as the Head Start program is responsible under the OCD Performance Standards for providing health screening for all its enrollees. In general, the role of Head Start as an effective supplier of health screening services is shown by the higher level of such screening among previously enrolled Head Start children.

On a national basis, 92% of the children participating at intake who had been previously enrolled in Head Start had also received screening as compared to 63% of children not previously enrolled who had been screened. Although the trend is less strong among the selected projects at 79% to 45%, prior enrollment in Head Start appeared to be most closely related to prior receipt of screening services.

The principal deviation from this trend appeared in the IMPD projects where only 56% of the children formerly in Head Start had been screened compared to 52% of not previously enrolled children who had been screened. This may be attributable to many of the Indian children receiving screening services through Indian Health Services.

Medicaid Certification/Prior Screening Services

At the time of intake, 41% of the Head Start children participating in the EPSDT Collaborative Effort were Medicaid certified, 3% were classified as not certified and 56% as "other" (not eligible or Medicaid eligibility unknown). Although it was expected that Medicaid certified children would be better able to obtain health services and be screened more frequently than the uncertified children, a child's status regarding Medicaid certification did not, in fact, have a strong influence on receipt of screening services overall.

On a national level, the proportion of Head Start children who had received screening was nearly identical in both instances: 71%

of the Medicaid certified and 70% of the not-Medicaid certified. Across regions there was considerable variation in the proportion of those screened who were Medicaid certified and not certified. The greatest differences between the two groups, with regard to the relationship of Medicaid certification to receipt of screening, occurred in Region III, where 90% of the Medicaid certified had been screened as compared to 73% of the non-certified. The pattern of more screening being received by Medicaid certified children was reversed in several regions--Regions IV, VII, VIII, and the IMPD projects--where the greater proportion of children who had received prior screening services were not-Medicaid Certified.

A relatively higher proportion of Medicaid ineligible and eligibility unknown children had been screened: 67% of those categorized as "other" had received such services prior to participation. There was, however, a large difference by region in the sceening of children categorized as "other". The lowest ratio of children falling into the "other" category who had been screened compared to those participating was in Region VII with 37%. In Region I, however, 83% of the children whose Medicaid status was unknown or ineligible at the time of entry into the collaboration had been screened in the preceding year.

2. The Selected Projects

The Head Start population participating in the EPSDT Collaborative Effort in the selected project was 4,399.* Individual project populations ranged from 13 children (Leominster), to 686 children (Amarillo). Across all selected projects, the proportion of children who were previously enrolled as compared to not previously enrolled was 18% (826/4,399). Among the projects, the ratio of previously enrolled to not previously enrolled varied widely--from one out of two children in Baltimore to none in Leominster' Toms River, and Trenton.

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*As previously noted, these totals reflect the combinations of "previously enrolled" and "not previously enrolled" only.

In the selected projects, the prevalence of prior screening among the previously enrolled population was generally high--in five projects, 100% of the previously enrolled Head Start children had been screened prior to intake. However, there were also marked deviations from this pattern. In Lubbock, only 20% of the previously enrolled had been screened prior to intake; and in East St. Louis, only 36%.

The Medicaid certification status of Head Start children screened varied among the selected projects. Of the projects reporting children who had received prior sceening services, 12 stated that over 70% of the entire Medicaid certified group had been screened before enrolling in the 1974-75 Head Start program year. On the other hand, one project reported no Head Start children who had been screened were Medicaid certified. There was some difference between the prevalence of screening received by Head Start children classified as "Other" within the selected projects (40%) and on the national level, where it averaged 67%.

C. CONCLUSIONS ON PREVIOUS HEALTH CARE: SCREENING OF HEAD START PARTICIPANTS

1. Relatively few Head Start children were carried over from the previous program year as reflected in the national average of 22%. It appeared that most children enrolled in Head Start only have one year's experience except for such specialized Head Start programs as IMPD.
2. For those children enrolled, the Head Start program had been highly successful in obtaining screening services which suggests significant compliance with OCD Performance Standards although the exact nature and extent of screening services obtained are unknown.
3. Less than 50% of the Head Start children participating were Medicaid certified, which suggests that Head Start programs relied to a great extent upon their own program resources to provide screening services.
4. The wide variation in Medicaid certification among the selected projects most likely reflects local conditions, such as the availability of community health resources, flexibility in the provision of Medicaid services within the state, and the initiative on the part of the individual project to utilize community resources.

D. RECOMMENDATIONS ON PREVIOUS HEALTH CARE: SCREENING OF HEAD START PARTICIPANTS

1. Since most children enrolled in the Head Start program benefit from these services for only one year, every effort should be made to ensure that all enrolled children receive screening services early in the program year so that adequate follow-up can be made. High priority should be assigned by OCD for monitoring individual programs for compliance with the Performance Standards in this regard.

2. Head Start programs should be provided assistance to ensure greater utilization of community health resources for the provision of screening services to augment their own program resources. This objective of the EPSDT Collaborative Effort as a specific program strategy appears to have much merit.

PREVIOUS HEALTH CARE: SCREENING OF HEAD START CHILDREN PARTICIPATING IN COLLABORATION EFFORT BY AGGREGATED TOTALS

TABLE IV	NATIONAL	SELECTED PROJECTS	ALL OTHER PROJECTS	REGIONS										
				I	II	III	IV	V	VI	VII	VIII	IX	X	IMPD
A. PARTICIPATING - INTAKE:														
1. Total	32,405	4,399	28,006	1,897	3,033	1,965	6,469	4,036	10,472	1,385	1,804	172	1,171	663
2. Previously Enrolled	7,343	826	6,517	257	442	474	1,778	696	2,658	363	418	16	241	266
3. Not Previously Enrolled	25,062	3,573	21,489	1,640	2,591	1,491	4,691	3,340	7,815	1,022	1,386	156	930	397
4. Medicaid Certified	13,448	2,403	11,045	1,279	2,093	785	1,911	2,335	2,739	721	765	85	735	197
5. Not Medicaid Certified	1,191	132	1,059	66	100	15	224	235	457	45	39	0	10	31
6. Other	17,580	1,836	15,744	537	797	1,154	4,295	1,448	7,238	610	993	85	423	431
B. SCREENED:														
1. Total	22,426	2,240	20,186	1,565	2,198	1,668	4,466	2,890	6,889	620	1,214	94	822	355
2. Previously Enrolled	6,762	649	6,113	239	390	473	1,618	655	2,530	318	298	14	227	149
3. Not Previously Enrolled	15,664	1,591	14,073	1,326	1,808	1,195	2,848	2,235	4,359	302	916	80	505	206
4. Medicaid Certified	9,608	1,449	8,159	1,057	1,487	705	1,284	1,661	1,951	371	514	49	534	83
5. Not Medicaid Certified	854	44	810	51	75	11	174	156	326	24	32	0	5	28
6. Other	11,832	727	11,105	445	608	941	2,979	1,063	4,586	223	663	44	280	242
C. %: SCREENED / PARTICIPATING														
1. Total	69	51	72	82	72	85	69	72	66	45	67	55	70	54
2. Previously Enrolled	92	79	94	93	88	99	91	94	95	88	71	88	94	56
3. Not Previously Enrolled	63	45	65	81	70	80	61	67	56	30	66	51	64	52
4. Medicaid Certified	71	60	74	83	71	90	67	71	71	51	67	94	73	42
5. Not Medicaid Certified	72	33	76	77	75	73	78	66	71	53	82	0	50	90
6. Other	67	40	71	83	76	82	69	73	63	37	67	52	66	56

PREVIOUS HEALTH CARE: SCREENING STATUS OF HEAD START CHILDREN PARTICIPATING IN COLLABORATION EFFORT BY SELECTED PROJECTS

TABLE IV-A	TOTAL SELECTED PROJECTS	MASS. (I)		NEW JERSEY (II)			MD. (III)	MISS. (IV)	TENN. (IV)	ILLINOIS (V)			OHIO (V)	
		Leominster	Worcester	Tome River	Paterson	Trenton	Baltimore	Cleveland	Kingston	Cook County	East St. Louis	Danville	Cincinnati	Dayton
A. PARTICIPATING - INTAKE:														
1. Total	4,399	13	389	121	182	174	450		161	645	285	281		
2. Previously Enrolled	826	0	3	0	44	0	215		30	174	25	80		
3. Not Previously Enrolled	3,573	13	386	121	138	174	235		131	471	260	201		
4. Medicaid Certified	2,403	8	266	88	179	132	316		41	389	203	172		
5. Not Medicaid Certified	132	1	6	0	0	1	0		2	4	58	4		
6. Other	1,836	4	116	32	2	36	126		118	243	23	105		
B. SCREENED:														
1. Total	2,240	7	384	87	44	117	446		111	321	96	152		
2. Previously Enrolled	649	0	3	0	18	0	215		28	168	9	77		
3. Not Previously Enrolled	1,591	7	381	87	26	117	231		83	153	87	75		
4. Medicaid Certified	1,445	5	263	62	43	90	313		32	191	73	9		
5. Not Medicaid Certified	44	0	6	0	0	0	0		2	2	17	2		
6. Other	727	2	114	24	0	23	125		77	123	6	55		
C. %: SCREENED / PARTICIPATING														
1. Total	51	54	99	72	24	67	99		69	50	34	54		
2. Previously Enrolled	79	N/A	100	N/A	41	N/A	100		93	97	36	96		
3. Not Previously Enrolled	45	54	99	72	19	67	98		63	32	33	37		
4. Medicaid Certified	60	63	99	70	24	68	99		76	49	36	55		
5. Not Medicaid Certified	33	N/A	100	N/A	N/A	N/A	N/A		100	50	29	50		
6. Other	40	29	98	75	N/A	64	99		65	51	26	52		

Note: Blank columns reflect those projects which have not submitted both the Intake Form and the End-Of-Year Status Report. Thus, no information is provided for these projects.

III-55

PREVIOUS HEALTH CARE: SCREENING STATUS OF HEAD START CHILDREN PARTICIPATING IN COLLABORATION EFFORT BY SELECTED PROJECTS

TABLE IV-A (CONTINUED)	TEXAS (VI)			MISSOURI (VII)		MONTANA (VIII)			CALIFORNIA (IX)		OREGON (X)	
	Lubbock	Amarillo	Laredo (IMPD)	Appleton	Spring-field	Billings	Blackfeet (IMPD)	Fort Peck (IMPD)	El Centro	Fresno (IMPD)	Eugene	Medford
PARTICIPATING - INTAKE:												
1. Total	231	686			119	160	79	173			118	132
2. Previously Enrolled	5	81			8	7	20	99			3	32
3. Not Previously Enrolled	226	605			111	153	59	74			115	100
4. Medicaid Certified	44	60			119	98	24	88			90	86
5. Not Medicaid Certified	0	50			0	0	0	1			4	1
6. Other	187	575			0	62	54	84			24	45
SCREENED:												
1. Total	8	116			117	38	46	0			89	61
2. Previously Enrolled	1	63			8	5	20	0			3	31
3. Not Previously Enrolled	7	53			109	33	26	0			86	30
4. Medicaid Certified	0	14			117	25	18	0			67	41
5. Not Medicaid Certified	0	12			0	0	0	0			3	0
6. Other	8	90			0	13	28	0			19	20
%: SCREENED / PARTICIPATING												
1. Total	3	17			98	24	58	N/A			75	46
2. Previously Enrolled	20	78			100	71	100	N/A			100	97
3. Not Previously Enrolled	3	9			98	22	44	N/A			75	30
4. Medicaid Certified	N/A	23			98	26	75	N/A			74	48
5. Not Medicaid Certified	N/A	24			N/A	N/A	N/A	N/A			75	N/A
6. Other	4	16			N/A	21	52	N/A			79	44

A PREVIOUS HEALTH CARE: TREATMENT RECEIVED BY HEAD START PARTICIPANTS (Table V and V-A)

A profile of treatment received by Head Start children during the year prior to enrollment is provided for all demonstration projects in Table V. Treatment includes medical, dental, mental health and nutritional services. The treatment categories are stratified by the Medicaid certification status of the children, i.e., children who are Medicaid certified, children not certified but eligible, and "other" (children whose Medicaid eligibility is unknown or who are, in fact, ineligible).

For purposes of this interim report, information was not obtained regarding previous health care in relation to diagnosis. It was assumed that, in those instances where treatment had actually been received, diagnosis would have, of necessity, been made. For those children who receive screening services as a result of the collaborative effort, information will be available in the final report regarding both diagnosis and treatment.

B. ANALYSIS OF FINDINGS ON PREVIOUS TREATMENT OF HEAD START PARTICIPANTS

1. National Sample

a. Medical Services

In the total national Head Start sample 5,500 (10% of the participating population) received medical treatment the year prior to enrollment. In the regions, the proportion of children who had received prior medical care ranged from 8% to 28%. Prior receipt of medical treatment was nearly evenly divided between those children who were Medicaid certified or eligible but not certified (2,641) and those classified as "other" (2,759). The child's status in this regard does not appear to have played any role in the receipt of medical care.

There was, however, regional variation in the receipt of medical treatment by the child's verification status. In Region IV, only 31% of the children who had received medical treatment were Medicaid certified or eligible, whereas in Regions I, II and VII approximately 70% of the children who had received medical treatment were Medicaid certified or not certified but eligible. One factor that may be operating in this regard is that State Medicaid Plans differ in the availability of treatment services. These differences would then govern the receipt of services by the Medicaid certified.

b. Dental Services

Approximately one out of three Head Start children had received dental screening/treatment. Regions VIII's Head Start population had the greatest proportion of children who had prior dental services (58%). At the lower range of the scale, only 23% of the children in Regions I and V had received treatment.

The number of children who had received dental screening/treatment and who were classified as "other," i.e., ineligible for Medicaid or of unknown status (6,204) exceeded the number of Medicaid certified and eligible but not certified (5,039) receiving such care. The major deviation from this pattern occurred in Region IV where only 703 of the Medicaid certified or eligible children received dental services but 1,589 (1/2 ratio) in the "other" category received such care.

c. Mental Health Services

Mental health services were received by a far lower proportion of children than received medical and dental care. Only 6% of the children participating in the Head Start/EPSDT effort received such services in the preceding year. The lowest incidence of mental health services prior to enrollment in the collaborative effort occurred in Regions I where 2% of the 1,882 Head Start population participating received services compared to the highest rate of 22% services received in the IMPD projects.

Again, Medicaid certification appeared to play no major role in receipt of mental health services. Nationally, 1,090 children who were Medicaid certified or eligible for such status received services and 1,149 children who were eligible or of unknown status also received care.

d. Nutritional Services

Nutritional services were received by only 3% of the Head Start population, and was therefore the least frequently obtained type of previous health care. A notable deviation occurred in the IMPD projects where 24% of the children had received nutritional care before enrollment in the collaborative effort. This difference apparently reflects the availability of resources for nutritional care in these communities. In addition, it may reflect a more nutritionally deficient environment for children entering Head Start in these areas.

2. Selected Projects

Previous medical, dental, mental health, and nutritional services received by Head Start children for the year prior to entry into the collaborative effort for 18 selected projects is identified in Table V-A. Within each area of service the children are differentiated by their Medicaid certification status.

In the selected projects, an average of 10% of the children entering the program had received medical treatment within the previous year and is consistent with the national average A wide range is evident in the medical treatment/participation ratio; for instance, little or no children had been treated in Toms River, East St. Louis, Lubbock, Blackfeet and Fort Peck, but 46 out of 132 children had received such care in Medford, Oregon. Because the profiles of the projects with low incidence of medical services received differ greatly, it is difficult to surmise reasons for this varying behavior.

Medicaid Certified and eligible but not certified children in the selected projects received medical treatment to a greater extent than those in the "other" category: 338 to 159.

In the selected projects, approximately one quarter of the children received dental screening/treatment services. The range in the receipt of these services was broad: from 2 out of 231 children in Lubbock to a high of 118 out of 119 in Springfield.

The receipt of mental health services by children in the selected projects occurred at a rate of 50%. The rate varied from no children in Leominster, East St. Louis and Eugene to all children enrolled in the Springfield Head Start project. Although the IMPD projects had a high proportion of children who had received mental health services (24%), the average rate of receipt in the selected IMPD projects was less than 1% which may reflect the lack of resources in these areas.

Previous receipt of nutritional services among children in the selected projects was at the rate of 1%, even less frequent than on the national level. Nine selected projects reported that none of their Head Start children had received nutritional services prior to entering the program. The IMPD regional data show a significantly higher receipt of nutritional services than in the IMPD selected projects. The lack of provision for nutritional services in the Montana State Plan may be an important contributory factor to the less frequent receipt of such services, since two of the three IMPD projects are in that state.

C. CONCLUSIONS ON PREVIOUS HEALTH CARE: TREATMENT OF HEAD START PARTICIPANTS

1. Greater proportions of Head Start children received dental screening/treatment than any other service. The higher incidences of dental screening/treatment service received may reflect the impact of the OCD Performance Standards.

2. Only 10% of the Head Start children had received medical treatment prior to entry into the collaborative effort. Medicaid certification or eligibility appears not to be a factor related to whether such services had been received. To the extent that regional variations existed, this probably reflected differences in the availability of medical services under the State Medicaid Plan. The receipt of nutritional and mental health services prior to entry was far less common among all reporting projects.

3. The differences in the incidence of various health services received may reflect the availability of these services in the particular area, either through Medicaid or private health resources; priorities set by the projects themselves regarding the relative importance of these services and/or actual needs.

D. RECOMMENDATIONS ON PREVIOUS HEALTH CARE: TREATMENT OF HEAD START PARTICIPANTS

1. Head Start programs should be provided assistance in gaining greater awareness of overall developmental health needs of pre-school children with particular stress upon mental health and nutrition.

2. OCD should press for national standards for the provision of health services to low-income pre-school children, thereby avoiding the dearth of service provisions triggered by limitations in individual state plans for Medicaid/EPSDT.

PREVIOUS HEALTH CARE: HEALTH STATUS OF HEAD START CHILDREN PARTICIPATING IN COLLABORATION EFFORT BY AGGREGATED TOTALS

TABLE V	NATIONAL	SELECTED PROJECTS	ALL OTHER PROJECTS	R E G I O N S										
				I	II	III	IV	V	VI	VII	VIII	IX	X	IMPD
A. PARTICIPATING INTAKE: 1. Total	32,219	4,371	27,848	1,882	2,990	1,954	6,430	4,018	10,434	1,376	1,797	170	1,168	659
2. Certified	13,448	2,403	11,045	1,279	2,093	785	1,911	2,335	2,739	721	765	85	735	197
3. Not Certified	1,191	132	1,059	66	100	15	224	235	457	45	39	0	10	31
4. Other	17,580	1,836	15,744	537	797	1,154	4,295	1,448	7,238	610	993	85	423	431
B. TREATMENT: 1. Total	5,500	497	5,003	390	575	271	747	940	1,657	127	509	25	259	53
2. Certified	2,557	333	2,224	275	397	123	185	575	495	88	246	11	162	20
3. Not Certified	184	5	179	11	16	1	51	50	49	2	3	0	1	1
4. Other	2,759	159	2,600	104	162	147	511	315	1,113	37	260	14	96	32
C. DENTAL: 1. Total	11,243	1,056	10,177	444	772	744	2,292	1,059	3,964	460	1,053	74	381	360
2. Certified	4,525	659	3,866	302	517	301	596	645	1,112	301	479	36	236	120
3. Not Certified	514	13	501	15	36	3	107	67	242	15	27	0	2	26
4. Other	6,204	394	5,810	127	219	440	1,509	347	2,610	144	547	38	143	214
D. MENTAL HEALTH: 1. Total	2,248	232	2,016	44	202	162	758	157	396	207	263	10	49	145
2. Certified	909	191	718	31	116	70	167	91	133	163	101	4	33	24
3. Not Certified	190	0	190	2	6	1	101	7	39	5	29	0	0	28
4. Other	1,149	41	1,108	11	80	91	490	59	224	39	133	6	16	93
E. NUTRITION: 1. Total	1,057	43	1,014	35	46	63	188	84	439	9	186	1	6	164
2. Certified	370	31	339	21	35	27	61	57	122	4	39	1	3	25
3. Not Certified	45	0	45	0	3	0	9	7	10	0	16	0	0	16
4. Other	642	12	630	14	8	36	118	20	307	5	131	0	3	123

PREVIOUS HEALTH CARE: HEALTH STATUS OF HEAD START CHILDREN PARTICIPATING IN COLLABORATION EFFORT BY SELECTED PROJECTS

TABLE V-A	TOTAL SELECTED PROJECTS	MASS. (I)		NEW JERSEY (II)			MD. (III)	TENN. (IV)	ILLINOIS (V)			OHIO (V)	
		Leominster	Worcester	Toms River	Paterson	Trenton	Baltimore	Kingston	Cook County	East St. Louis	Danville	Cincinnati	Dayton
A. PARTICIPATING INTAKE:													
1. Total	4,371	13	388	120	181	169	442	161	636	284	281		
2. Certified	2,403	8	266	88	179	132	316	41	389	203	172		
3. Not Certified	132	1	6	0	0	1	0	2	4	58	4		
4. Other	1,836	4	116	32	2	36	126	118	243	23	105		
B. TREATMENT:													
1. Total	497	7	70	2	16	29	50	44	110	0	63		
2. Certified	333	5	47	2	16	28	44	14	68	0	43		
3. Not Certified	5	0	1	0	0	0	0	1	2	0	0		
4. Other	159	2	22	0	0	1	6	29	40	0	20		
C. DENTAL:													
1. Total	1,066	4	59	2	3	5	183	91	195	22	57		
2. Certified	659	2	26	2	3	4	126	29	115	20	40		
3. Not Certified	13	0	1	0	0	0	0	1	0	0	0		
4. Other	394	2	32	0	0	1	57	61	80	2	17		
D. MENTAL HEALTH:													
1. Total	232	0	3	1	8	7	8	2	54	0	8		
2. Certified	191	0	0	0	8	6	7	0	35	0	6		
3. Not Certified	0	0	0	0	0	0	0	0	0	0	0		
4. Other	41	0	3	1	0	1	1	2	19	0	2		
E. NUTRITION:													
1. Total	43	1	1	0	2	3	1	2	11	0	16		
2. Certified	31	0	1	0	2	2	1	1	10	0	13		
3. Not Certified	0	0	0	0	0	0	0	0	0	0	0		
4. Other	12	1	0	0	0	1	0	1	1	0	3		

Note: Blank columns reflect those projects which have not submitted both the Intake Form and the End-Of-Year Status Report. Thus, no information is provided for these projects.

PREVIOUS HEALTH CARE: HEALTH STATUS OF HEAD START CHILDREN PARTICIPATING IN COLLABORATION BY SELECTED PROJECTS

TABLE V-A (CONTINUED)	TEXAS (VI)			MISSOURI (VII)		MONTANA (V III)			CALIFORNIA (IX)		OREGON (X)	
	Lubbock	Amarillo	Laredo (IMPD)	Appleton	Spring-field	Billings	Blackfeet (IMPD)	Fort Peck (IMPD)	El Centro	Fresno (IMPD)	Eugene	Medford
A. PARTICIPATING INTAKE:												
1. Total	231	685			119	160	78	173			118	132
2. Certified	44	60			119	98	24	88			90	86
3. Not Certified	0	50			0	0	0	1			4	1
4. Other	187	575			0	62	54	84			24	45
B. TREATMENT:												
1. Total	2	21			12	15	1	1			8	46
2. Certified	0	4			12	10	0	0			6	34
3. Not Certified	0	1			0	0	0	0			0	0
4. Other	2	16			0	5	1	1			2	12
C. DENTAL:												
1. Total	2	65			118	48	10	122			32	48
2. Certified	0	10			118	28	6	74			25	31
3. Not Certified	0	9			0	0	0	1			0	1
4. Other	2	46			0	20	4	47			7	11
D. MENTAL HEALTH:												
1. Total	1	6			119	6	1	1			0	7
2. Certified	0	1			119	4	1	0			0	4
3. Not Certified	0	0			0	0	0	0			0	0
4. Other	1	5			0	2	0	1			0	3
E. NUTRITION:												
1. Total	0	6			0	0	0	0			0	0
2. Certified	0	1			0	0	0	0			0	0
3. Not Certified	0	0			0	0	0	0			0	0
4. Other	0	5			0	0	0	0			0	0

A. PREVIOUS HEALTH CARE STATUS OF NON-HEAD START CHILDREN (Table VI and VI-A)

Data pertaining to the prior screening and treatment of non-Head Start children stratified by Medicaid certification status is pesented in Table VI and VI-A. The major categories of the tables are:

- Participating Population at Intake
- Those who have Received Treatment within a Year prior to Enrollment
- The Per Cent of Screened Participating Children
- Prior Treatment by Service Category.

The data is arrayed within each service category (screening medical, dental, mental health, and nutritional) by the Medicaid certification status of the children. Since one of the objectives of the EPSDT Collaborative Effort was to recruit Medicaid eligible non-Head Start children, Medicaid status is broken down by Medicaid certified and non-Medicaid certified, i.e., eligible but not certified. These categories will not add to the total which includes "others". Non-responses also are not shown.

B. ANALYSIS OF FINDINGS ON PREVIOUS HEALTH CARE OF NON-HEAD START CHILDREN

1. National Sample

Of the 6,002 non-Head Start children participating at intake, 4,531 or 73% of this population were Medicaid certified and 2 out of 3 of these were siblings of Head Start enrollees.

a. Screening Services

Out of the total non-Head Start children participating, 59% had been screened prior to coming into contact with the EPSDT Collaborative Effort. There was variation in the proportion of screened to participating children across regions. The percentage of children who had received screening ranged from a low of 38% of non-Head Start children in Region VII to a high of 92% of such children in Region IX.

On a national basis, a majority of non-Head Start children, 75%, who had been screened were certified or not certified but eligible for Medicaid, compared to 71% of the Head Start population. This pattern is consistent with the data shown on Table IV for Head Start children. It should be noted that siblings of Head Start children accounted for over 50% of the Medicaid certified population that had been screened.

The certification profile for the non-Head Start child who had been screened varied by region from 46% to 99% of the non-Head Start population. In Regions I, III and the IMPD projects, more non-siblings who were Medicaid certified had been screened than siblings.

b. Medical Treatment

Nationally, one in five non-Head Start children had received medical treatment within the year prior to the involvement with the collaborative effort. 80% of those receiving this treatment were Medicaid certified and, with respect to sibling status, slightly half of them were siblings of Head Start children. This pattern of high incidence of Medicaid certified non-Head Start children receiving treatment prior to the collaborative effort holds true across all regions. Five regions reported that they had more non-siblings than siblings who had received such services however.

c. Dental Services

Among the non-Head Start children, one out of five also received dental screening/treatment as compared to one out of three Head Start children. The highest incidence of receipt of dental services occurred in Region VIII where 41% of the children had received dental services prior to the collaborative effort. This region had the highest proportion of Head Start children receiving dental services also. The lowest incidence of such services received was reported in Regions IV and VII at 11%. However, most of the regions approximated the national average.

85% of the non-Head Start children who had received dental services were Medicaid certified, and over 50% of these (621 out of 1,101) were siblings of Head Start children. Of the not Medicaid certified group, slightly more than 50% were non-siblings. This pattern holds true across all regions with an increase in Regions V and VII where almost all the non-Head Start children receiving dental services were Medicaid certified. In reviewing the sibling dental services, Regions, I, III, V, and the IMPD projects report that the greater number of non-Head Start children who were Medicaid certified were non-siblings.

d. Mental Health Services

On the national level, 3% of the non-Head Start children had received mental health services within a year of entering the colaborative effort compared to the national average of 6% for Head Start children. The IMPD projects deviated more sharply from this average with 11% of these children having received mental health care prior to involvement with the collaborative effort. Region I had the next highest proportion of non-Head Start children receiving mental health services at 10%. In four regions, 1% or less of the non-Head Start children had received mental health services. In each region, nearly all of the non-Head Start children receiving mental health services prior to entry were Medicaid certified, and most of them were siblings of Head Start enrollees. The high incidence of Medicaid certification among non-Head children receiving mental health service differs markedly from the Head Start population where Medicaid certification was not a distinguishing factor among those children who had received mental health services prior to entry into the program.

e. Nutritional Services

Of the non-Head Start children participating at intake, 4% of them had received nutritional services prior to entry. Again, for the non-Head Start population, the receipt of such service appears to be related to Medicaid status: more than three-fourths of the children receiving nutritional services were either certified or eligible.

As with the previous categories of health services, the majority, 61% in the case of nutritional services, of the non-Head Start Medicaid certified participants were siblings of Head Start enrollees. In Region III, V, VI and the IMPD projects, there was some deviation from this pattern with a higher number of non-siblings or other/unknowns being recorded.

2. Selected Projects

The total number of non-Head population that participated at intake within the selected projects was 783 or 13% of the national total. Of the 18 selected projects under review, four--Toms River, Danville, Blackfeet and Fort Peck--did not report any non-Head Start children participating at intake.

82% of the non-Head Start children participating in the remaining 14 projects were Medicaid certified and 75% of these were siblings of enrollees. Of the non-Medicaid certified group, none were non-siblings. 48% of the non-Head Start children in the selected projects had been medically screened within a year prior to enrollment as contrasted to 59% of non-Head Start children nationally who had received such services. Of the medically screened in the selected projects, 52% were Medicaid certified. Most of the selected projects that served children who had received screening prior to entry reported a higher incidence (over 50%) than the average. However, East St. Louis and Amarillo reported one child or less in this category, thereby skewing the average.

Of the non-Head Start children screened, 90% were Medicaid certified and more than half were siblings of enrollees. This pattern holds true in all projects except Baltimore where almost all non-Head Start Medicaid certified children screened were non-siblings. Baltimore also reported three not Medicaid certified non-siblings screened, but indicated no non-siblings at intake. This inconsistency most likely reflects the project's failure to submit the appropriate number of forms (Intake and Health Encounter) for each non-Head Start child served.

Among the 14 projects reporting non-Head Start children participating in the program, 8% of these children had received medical treatment within a year of enrollment. This is a lower ratio than that for the national sample, one out of five non-Head Start children in receipt of such services. The highest incidence of previous medical treatment received--49%--occurred in the Medford project. Six projects reported that none of the non-Head Start children participating at intake had received medical treatment. 80% of the non-Head Start children who had received medical treatment were Medicaid certified as well as siblings of Head Start enrollees.

Nearly one out of four of the non-Head Start children received dental screening/treatment in the selected projects. In contrast, one out of five non-Head Start children had received dental services in the total sample. The overwhelming majority of the non-Head Start children in this group were Medicaid certified and siblings of Head Start enrollees, except in Baltimore where all of the non-Head Start children receiving dental services were non-siblings. In six projects, none of the non-Head Start children received dental services.

In another area, mental health services, 7% of the non-Head Start children in the selected process had received such care compared to 3% of these children on a national basis. Medicaid certification of non-Head Start children in the selected projects may have influenced the receipt of mental health services, since 56 out of 58 of the non-Head Start children were Medicaid certified or eligible. This rate is somewhat higher than the national pattern shown in Table VI for non-Head Start children. 55 out of the 58 non-Head Start children who had received mental health services were reported to be participants in the Paterson project, and nearly all of these were Medicaid certified and siblings of Head Start enrollees. Eleven projects, on the other hand, indicated that none of their non-Head Start children had received mental health services prior to entry and one project had only one child who had received mental health services.

Similarly, only three projects reported that their non-Head Start children had received nutritional services prior to program entry. Paterson again reported the majority of the children--54 out of 56 non-Head Start children--so reported. As in mental health services, nearly all of the children in the Paterson project were Medicaid certified and siblings of Head Start enrollees.

C. CONCLUSIONS ON PREVIOUS HEALTH CARE OF NON-HEAD START CHILDREN

1. The majority of the non-Head Start children participating in the collaborative effort as evidenced by the completion of intake forms, were Medicaid certified and two out of three of them were siblings of Head Start enrollees. It would appear therefore that the Head Start projects primarily recruited non-Head Start participants for the collaborative effort from the Head Start families currently enrolled.

2. 59% of the non-Head Start children as compared to 69% of the Head Start children had received screening services prior to entry into the collaborative effort. This similarity in incidence, accounting for sampling bias, may reflect concentration by some Head Start projects in providing for family health services rather than focusing upon the needs of the enrolled Head Start child only.

3. Relatively few, approximately 20% of the non-Head Start children, received medical treatment services prior to entry into the program, but most of these were Medicaid certified.

4. The incidence of dental services received was lower for non-Head Start children than Head Start children--one out of five compared to one out of three. This difference most likely reflects the priority placed in the Head Start projects upon providing dental services for its enrollees.

5. There were some differences in the receipt of mental health and nutritional services between Head Start and non-Head Start populations nationally. However, because of the relatively low number of participants receiving these services, no conclusions should be drawn. It is interesting to note, however, that most of the non-Head Start children receiving mental health and nutritional services were Medicaid certified.

6. For the selected projects, the distribution of non-Head Start children by service category, Medicaid certification, and sibling status is similar to the pattern presented nationally. Baltimore, which served more non-siblings than siblings is a notable exception.

7. Prior mental health and nutritional services are virtually nonexistent for non-Head Start children except in the case of Paterson. The fact that this particular project was able to be garner such services for its non-Head Start children may reflect the availability of resources in the community, including liberal Medicaid standards, and the initiatives by the project's staff to secure services for all its participants.

D. RECOMMENDATIONS ON PREVIOUS HEALTH CARE OF NON-HEAD START CHILDREN

1. Head Start programs should be encouraged to arrange for family health services, thereby ensuring that all family members, including the children, have comprehensive health care. Such program initiative, however, must take into account limited staff resources.

2. If the EPSDT collaborative effort is to be effective, Head Start projects should be assisted in defining their responsibility for recruiting participants beyond the immediate Head Start family. Within this context, OCD should clarify with the Social and Rehabilitation Services unit the extent to which Head Start programs should be responsible for recruiting participants in the general community.

PREVIOUS HEALTH CARE: HEALTH STATUS OF NON-HEAD START CHILDREN PARTICIPATING IN COLLABORATION EFFORT BY AGGREGATED TOTALS

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TABLE VI	NATIONAL	SELECTED PROJECTS	ALL OTHER PROJECTS	REGIONS I	II	III	IV	V	VI	VII	VIII	IX	X	IMPD
A. PARTICIPATING INTAKE: 1. Total *	6,002	783	5,219	884	894	314	1,373	646	784	150	412	69	476	115
2. Medicaid Certified	4,531	653	3,878	573	754	287	975	550	525	129	321	41	376	52
a) Siblings	2,658	511	2,147	171	477	73	579	338	387	92	277	37	227	13
b) Non-Siblings	1,690	112	1,578	331	273	211	393	197	88	28	35	1	133	37
c) Other	183	30	153	71	4	3	3	15	50	9	9	3	16	2
3. Not Medicaid Certified	238	53	185	36	60	8	30	49	36	2	10	0	7	10
a) Sibling	100	53	47	14	25	0	2	49	8	0	1	0	1	1
b) Non-Sibling	130	0	130	20	35	8	28	0	24	1	8	0	6	8
c) Other	8	0	8	2	0	0	0	0	4	1	1	0	0	1
B. SCREENED: 1. Total *	3,584	376	3,208	707	518	263	685	354	359	57	325	64	252	89
2. Medicaid Certified	2,727	341	2,386	450	437	238	483	329	239	55	251	36	209	41
a) Siblings	1,463	228	1,235	133	242	44	263	201	160	28	221	33	138	10
b) Non-Siblings	1,262	113	1,149	316	195	194	220	128	78	27	30	3	71	31
c) Other	2	0	2	1	0	0	0	0	1	0	0	0	0	0
3. Not Medicaid Certified	122	5	117	21	48	8	3	7	24	1	8	0	2	8
a) Siblings	34	2	32	9	14	0	0	7	2	0	1	0	1	1
b) Non-Siblings	88	3	85	12	34	8	3	0	22	1	7	0	1	7
c) Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0
C. % SCREENED / PARTICIPATING 1. Total	59	48	61	79	57	83	49	54	45	38	78	92	52	77
2. Medicaid Certified	60	52	61	78	57	82	49	59	45	42	78	87	55	78
3. Not Medicaid Certified	51	9	63	58	80	100	10	14	66	50	80	N/A	28	80

* Columns 2 and 3 will not add to total column because the categories of "Not Eligible for Medicaid" and " [illegible]

PREVIOUS HEALTH CARE: HEALTH STATUS OF NON-HEAD START CHILDREN PARTICIPATING IN COLLABORATION EFFORT BY AGGREGATED TOTALS

TABLE VI (CONTINUED)	NATIONAL	SELECTED PROJECTS	ALL OTHER PROJECTS	R	E	G	I	O	N	S				
				I	II	III	IV	V	VI	VII	VIII	IX	X	IMPD
D. TREATMENT 1. Total *	1,142	70	1,072	254	207	28	100	213	81	3	123	6	127	4
2. Medicaid Certified	922	60	862	169	171	25	58	202	66	3	114	5	109	2
a) Siblings	486	49	437	59	89	6	24	88	41	3	109	5	62	1
b) Non-Siblings	409	2	407	103	82	19	34	110	17	0	4	0	40	1
c) Other	27	9	18	7	0	0	0	4	8	0	1	0	7	0
3. Not Medicaid Certified	47	0	47	14	25	0	2	3	2	0	0	0	1	0
a) Sibling	16	0	16	5	9	0	0	2	0	0	0	0	0	0
b) Non-Sibling	29	0	29	8	16	0	2	0	2	0	0	0	1	0
c) Other	2	0	2	1	0	0	0	1	0	0	0	0	0	0
E. DENTAL 1. Total *	1,294	187	1,107	145	198	79	264	183	137	17	170	10	91	28
2. Medicaid Certified	1,101	175	926	108	177	70	231	182	91	17	141	5	79	11
a) Siblings	621	148	473	36	109	13	126	87	47	7	126	5	65	0
b) Non-Siblings	437	21	416	65	68	55	105	91	26	9	9	0	9	11
c) Other	43	6	37	7	0	2	0	4	18	1	6	0	5	0
3. Not Medicaid Certified	32	2	30	8	10	0	1	0	6	0	6	0	1	6
a) Siblings	11	2	9	1	10	0	0	0	0	0	0	0	0	0
b) Non-Siblings	17	0	17	6	0	0	1	0	4	0	5	0	1	5
c) Other	4	0	4	1	0	0	0	0	2	0	1	0	0	1

* Columns 2 and 3 will not add to total column because the categories of " Not Eligible for Medicaid" and " Medicaid Eligibility Unknown" were not tabulated.

PREVIOUS HEALTH CARE: HEALTH STATUS OF NON-HEAD START CHILDREN PARTICIPATING IN COLLABORATION EFFORT BY AGGREGATED TOTALS

TABLE VI (CONTINUED)	NATIONAL	SELECTED PROJECTS	ALL OTHER PROJECTS	R E G I O N S										
				I	II	III	IV	V	VI	VII	VIII	IX	X	INTD
F. MENTAL HEALTH: 1. Total *	202	58	144	16	69	2	32	17	21	2	36	1	6	12
2. Medicaid Certified	172	56	116	10	67	2	29	17	18	2	21	1	5	1
a) Siblings	119	52	67	5	54	1	14	6	18	0	18	1	2	0
b) Non-Siblings	50	4	46	5	13	1	15	10	0	1	2	0	3	1
c) Other	3	0	3	0	0	0	0	1	0	1	1	0	0	0
3. Not Medicaid Certified	15	2	13	4	2	0	1	0	1	0	7	0	0	7
a) Siblings	4	2	2	1	2	0	0	0	0	0	1	0	0	1
b) Non-Siblings	9	0	9	2	0	0	1	0	1	0	5	0	0	5
c) Other	2	0	2	1	0	0	0	0	0	0	1	0	0	1
G. NUTRITION: 1. Total *	287	56	231	71	112	12	8	7	4	0	69	0	4	46
2. Medicaid Certified	216	54	162	51	105	12	7	7	4	0	27	0	3	5
a) Siblings	133	54	79	38	58	5	5	2	1	0	22	0	2	1
b) Non-Siblings	79	0	79	13	47	7	2	5	0	0	4	0	1	4
c) Other	4	0	4	0	0	0	0	0	3	0	1	0	0	0
3. Not Medicaid Certified	12	2	10	3	5	0	0	0	0	0	3	0	1	3
a) Siblings	7	2	5	1	4	0	0	0	0	0	1	0	1	1
b) Non-Siblings	4	0	4	2	1	0	0	0	0	0	1	0	0	1
c) Other	1	0	1	0	0	0	0	0	0	0	1	0	0	[illegible]

* Columns 2 and 3 will not add to total column because the categories of "Not Eligible for Medicaid" and "Medicaid Eligibility Unknown" were not tabulated.

PREVIOUS HEALTH CARE: HEALTH STATUS OF NON-HEAD START CHILDREN PARTICIPATING IN COLLABORATION EFFORT BY SELECTED PROJECTS

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TABLE VI-A	TOTAL SELECTED PROJECTS	MASS. (I)		NEW JERSEY (II)			MD. (III)	MISS. (IV)	TENN. (IV)	ILLINOIS (V)			OHIO (V)	
		Leominster	Worcester	Toms River	Paterson	Trenton	Baltimore	Cleveland	Kingston	Cook County	East St. Louis	Danville	Cincinnati	Dayton
A. PARTICIPATING INTAKE														
1. Total*	783	2	13	0	152	83	88		64	3	150	0		
2. Medicaid Certified	653	2	12	0	143	67	81		64	3	92	0		
a) Siblings	511	1	0	0	137	64	2		64	1	85	0		
b) Non-Siblings	112	1	0	0	6	1	79		0	0	6	0		
c) Other	30	0	12	0	0	2	0		0	2	1	0		
3. Not Medicaid Certified	53	0	0	0	8	2	3		0	0	40	0		
a) Siblings	53	0	0	0	8	2	3		0	0	40	0		
b) Non-Siblings	0	0	0	0	0	0	0		0	0	0	0		
c) Other	0	0	0	0	0	0	0		0	0	0	0		
B. SCREENED: 1. Total*	376	1	13	0	85	36	86		30	2	1	0		
2. Medicaid Certified	341	1	12	0	83	30	79		30	2	1	0		
a) Siblings	228	1	0	0	78	27	2		30	2	1	0		
b) Non-Siblings	113	0	12	0	5	3	77		0	0	0	0		
c) Other	0	0	0	0	0	0	0		0	0	0	0		
3. Not Medicaid Certified	5	0	0	0	2	0	3		0	0	0	0		
a) Siblings	2	0	0	0	2	0	0		0	0	0	0		
b) Non-Siblings	3	0	0	0	0	0	3		0	0	0	0		
c) Other	0	0	0	0	0	0	0		0	0	0	0		
C. SCREENED % PARTICIPATING 1. [illegible]	48	50	100	N/A	55	43	97		46	66	Less than 1	N/A		
2. Medicaid Certified	52	50	100	N/A	58	44	97		46	66	1	N/A		
3. Not Medicaid Certified	9	0	0	N/A	25	N/A	100		N/A	N/A	N/A	N/A		

*Columns 2 and 3 will not add to total column because the categories of "not Eligible for Medicaid" and "Medicaid Eligibility" were not tabulated

PREVIOUS HEALTH CARE: HEALTH STATUS OF NON-HEAD START CHILDREN PARTICIPATING IN COLLABORATION EFFORT BY SELECTED PROJECTS

TABLE VI-A (CONTINUED)	TEXAS (VI)			MISSOURI (VII)		MONTANA (VIII)			CALIFORNIA (IX)		OREGON (X)			
	Lubbock	Amarillo	Laredo (IHPD)	Appleton	Springfield	Billings	Blackfeet (IHPD)	Fort Peck (IHPD)	El Centro	Fresno (IHPD)	Eugene	Medford		
A. PARTICIPATING INTAKE:														
1. Total*	2	45			5	30		0			101	45		
2. Medicaid Certified	1	38			5	17		0			97	31		
a) Siblings	0	37			5	1		0			96	18		
b) Non-Siblings	1	1			0	16		0			1	0		
c) Other	0	0			0	0		0			0	13		
3. Not Medicaid Certified	0	0			0	0		0			0	0		
a) Siblings	0	0			0	0		0			0	0		
b) Non-Siblings	0	0			0	0		0			0	0		
c) Other	0	0			0	0		0			0	0		
B. SCREENED:														
1. Total*	0	0			5	21		0			82	14		
2. Medicaid Certified	0	0			5	10		0			78	10		
a) Siblings	0	0			5	0		0			77	5		
b) Non-Siblings	0	0			0	10		0			1	5		
c) Other	0	0			0	0		0			0	0		
3. Not Medicaid Certified	0	0			0	0		0			0	0		
a) Siblings	0	0			0	0		0			0	0		
b) Non-Siblings	0	0			0	0		0			0	0		
c) Other	0	0			0	0		0			0	0		
C. % SCREENED PARTICIPATING														
1. Total	N/A	N/A			100	70		N/A			81	31		
2. Medicaid Certified	N/A	N/A			100	58		N/A			80	32		
3. Not Medicaid Certified	N/A	N/A			N/A	N/A		N/A			N/A	N/A		

*Columns 2 and 3 will not add to total column because the categories of "not Eligible for Medicaid" and "Medicaid Eligibility" were not tabulated

PREVIOUS HEALTH CARE: HEALTH STATUS OF NON-HEAD START CHILDREN PARTICIPATING IN COLLABORATION EFFORT BY SELECTED PROJECTS

TABLE VI-A (CONTINUED)	TOTAL SELECTED PROJECTS	MASS. (I)		NEW JERSEY (II)			MD.	MISS. (IV)	TENN. (IV)	ILLINOIS (V)			OHIO (V)	
		Leominster	Worcester	Toms River	Paterson	Trenton	Balti.	Cleveland	Kingston	Cook County	East St. Louis	Danville	Cincinnati	Dayton
D. TREATMENT														
1. Total*	70	0	4	0	9	4	3		8	0	0	0		
2. Medicaid Certified	60	0	4	0	9	4	2		8	0	0	0		
a) Siblings	49	0	0	0	9	4	0		8	0	0	0		
b) Non-Siblings	2	0	0	0	0	0	2		0	0	0	0		
c) Other	9	0	4	0	0	0	0		0	0	0	0		
3. Not Medicaid Certified	0	0	0	0	0	0	0		0	0	0	0		
a) Siblings	0	0	0	0	0	0	0		0	0	0	0		
b) Non-Siblings	0	0	0	0	0	0	0		0	0	0	0		
c) Other	0	0	0	0	0	0	0		0	0	0	0		
E. DENTAL:														
1. Total*	187	0	2	0	68	0	18		28	0	0	0		
2. Medicaid Certified	175	0	2	0	66	0	17		28	0	0	0		
a) Siblings	148	0	0	0	62	0	0		28	0	0	0		
b) Non-Siblings	21	0	0	0	4	0	17		0	0	0	0		
c) Other	6	0	2	0	0	0	0		0	0	0	0		
3. Not Medicaid Certified	2	0	0	0	2	0	0		0	0	0	0		
a) Siblings	2	0	0	0	2	0	0		0	0	0	0		
b) Non-Siblings	0	0	0	0	0	0	0		0	0	0	0		
c) Other	0	0	0	0	0	0	0		0	0	0	0		

*Columns 2 and 3 will not add to total column because the categories of "not Eligible for Medicaid" and "Medicaid Eligibility" were not tabulated

PREVIOUS HEALTH CARE: HEALTH STATUS OF NON-HEAD START CHILDREN PARTICIPATING IN COLLABORATION EFFORT BY SELECTED PROJECTS

TABLE VI-A (CONTINUED)	TEXAS (VI)			MISSOURI (VII)		MONTANA (VIII)			CALIFORNIA (IX)		OREGON (X)			
	Lubbock	Amarillo	Laredo (IMPD)	Appleton	Spring-field	Billings	Blackfeet (IMPD)	Fort Peck (IMPD)	El Centro	Fresno (IMPD)	Eugene	Medford		
D. TREATMENT														
1. Total*	0	0			3	0		0			17	22		
2. Medicaid Certified	0	0			3	0		0			14	16		
a) Siblings	0	0			3	3		0			14	11		
b) Non-Siblings	0	0			0	0		0			0	0		
c) Other	0	0			0	0		0			0	5		
3. Not Medicaid Certified	0	0			0	0		0			0	0		
a) Siblings	0	0			0	0		0			0	0		
b) Non-Siblings	0	0			0	0		0			0	0		
c) Other	0	0			0	0		0			0	0		
E. DENTAL														
1. Total*	0	0			4	3		0			57	7		
2. Medicaid Certified	0	0			4	1		0			53	4		
a) Siblings	0	0			4	1		0			53	0		
b) Non-Siblings	0	0			0	0		0			0	0		
c) Other	0	0			0	0		0			0	4		
3. Not Medicaid Certified	0	0			0	0		0			0	0		
a) Siblings	0	0			0	0		0			0	0		
b) Non-Siblings	0	0			0	0		0			0	0		
c) Other	0	0			0	0		0			0	0		

*Columns 2 and 3 will not add to total column because the categories of "not Eligible for Medicaid" and "Medicaid Eligibility" were not tabulated

PREVIOUS HEALTH CARE: HEALTH STATUS OF NON-HEAD START CHILDREN PARTICIPATING IN COLLABORATION EFFORT BY SELECTED PROJECTS

TABLE VI-A (CONTINUED)	TOTAL SELECTED PROJECTS	MASS. (I)		NEW JERSEY (II)			MD. (III)	MISS. (IV)	TENN. (IV)	ILLINOIS (V)			OHIO (V)	
		Leominster	Worcester	Toms River	Paterson	Trenton	Baltimore	Cleveland	Kingston	Cook County	East St. Louis	Danville	Cincinnati	Dayton
F. MENTAL HEALTH: 1. Total*	58	0	0	0	55	0	0		2	0	0	0		
2. Medicaid Certified	56	0	0	0	53	0	0		2	0	0	0		
a) Siblings	52	0	0	0	49	0	0		2	0	0	0		
b) Non-Siblings	4	0	0	0	4	0	0		0	0	0	0		
c) Other	0	0	0	0	0	0	0		0	0	0	0		
3. Not Medicaid Certified	2	0	0	0	2	0	0		0	0	0	0		
a) Siblings	2	0	0	0	2	0	0		0	0	0	0		
b) Non-Siblings	0	0	0	0	0	0	0		0	0	0	0		
c) Other	0	0	0	0	0	0	0		0	0	0	0		
G. NUTRITION: 1. Total*	56	0	0	0	54	0	0		1	0	0	0		
2. Medicaid Certified	54	0	0	0	52	0	0		1	0	0	0		
a) Siblings	54	0	0	0	52	0	0		1	0	0	0		
b) Non-Siblings	0	0	0	0	0	0	0		0	0	0	0		
c) Other	0	0	0	0	0	0	0		0	0	0	0		
3. Not Medicaid Certified	2	0	0	0	2	0	0		0	0	0	0		
a) Siblings	2	0	0	0	2	0	0		0	0	0	0		
b) Non-Siblings	0	0	0	0	0	0	0		0	0	0	0		
c) Other	0	0	0	0	0	0	0		0	0	0	0		

*Columns 2 and 3 will not add to total column because the categories of "not Eligible for Medicaid" and "Medicaid Eligibility" were not tabulated

PREVIOUS HEALTH CARE: HEALTH STATUS OF NON-HEAD START CHILDREN PARTICIPATING IN COLLABORATION EFFORT BY SELECTED PROJECTS

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TABLE VI-A (CONTINUED)	TEXAS (VI)			MISSOURI (VII)		MONTANA (VIII)			CALIFORNIA (IX)		OREGON (X)			
	Lubbock	Amarillo	Laredo (IMPD)	Appleton	Springfield	Billings	Blackfeet (IMPD)	Fort Peck (IMPD)	El Centro	Fresno (IMPD)	Eugene	Medford		
F. MENTAL HEALTH:														
1. Total*	0	0			0	1		0			0	0		
2. Medicaid Certified	0	0			0	1		0			0	0		
a) Siblings	0	0			0	1		0			0	0		
b) Non-siblings	0	0			0	0		0			0	0		
c) Other	0	0			0	0		0			0	0		
3. Not Medicaid Certified	0	0			0	0		0			0	0		
a) Siblings	0	0			0	0		0			0	0		
b) Non-siblings	0	0			0	0		0			0	0		
c) Other	0	0			0	0		0			0	0		
G. NUTRITION:														
1. Total*	0	0			0	0		0			1	0		
2. Medicaid Certified	0	0			0	0		0			1	0		
a) Siblings	0	0			0	0		0			1	0		
b) Non-Siblings	0	0			0	0		0			0	0		
c) Other	0	0			0	0		0			0	0		
3. Not Medicaid Certified	0	0			0	0		0			0	0		
a) Siblings	0	0			0	0		0			0	0		
b) Non-Siblings	0	0			0	0		0			0	0		
c) Other	0	0			0	0		0			0	0		

*Columns 2 and 3 will not add to total column because the categories of "not Eligible for Medicaid" and "Medicaid Eligibility" were not tabulated

IV. ORGANIZATION AND OPERATION OF EPSDT

Introduction

The Head Start/EPSDT Collaborative Effort was established to strengthen the Head Start health component and assist in the achievement of Title XIX objectives. It was further designed to improve health services for children 0-6 years of age and, wherever possible, to integrate Head Start into the Medicaid reimbursement system. This demonstration program is being implemented through 198 Head Start programs which have received supplemental grants from OCD.

The guidelines for the demonstration programs required necessary modifications in organization and operation of the Head Start projects, such as an expanded role for the Health Services Coordinator and provisions for EPSDT-related public information, transportation, and recordkeeping. Modifications in programs were made, however, within the projects' understanding of these guidelines, as well as their status prior to EPSDT, relations with state and local agencies, and various other factors.

This section describes the ways in which the collaborative effort was organized and operated by the demonstration projects during the first year. The 25 selected projects provided the basis for the detailed information presented in this interim report. Important aspects of management and staffing, organization and planning, supportive services and health service arrangements are presented.

The operations and the initial results of outreach, follow-up, and recordkeeping are also described. Important trends across the projects are discussed,as are underlying factors related to them.

OCD guidelines for the Head Start/EPSDT Collaborative Effort require that the health services coordinator in the individual Head Start project be responsible for the administration and coordination of the EPSDT Collaborative Effort. The supplemental grant approved for the demonstration program was to be used either to increase the number of weekly working hours of the health services coordinator currently on staff or to employ additional personnel.

Responsibility for managing the Head Start/EPSDT Collaborative Effort in the selected projects is primarily vested in the health services coordinators, or equivalent positions. Of the 25 projects analyzed, 16 took this approach, with the coordinators being responsible for design, operation and administration of the demonstration activities. In seven projects, responsibility was shared between the Head Start directors and the coordinators. Directors focused on design, overall administration and coordination in these instances, and the coordinators on operations and administrative details. One Head Start director had total management responsibility as did one social services director.

The primary factor in these instances was the director's assessment of the importance of the collaborative effort and of the respective capabilities of staff.

Characteristics of staff and their knowledge of EPSDT are discussed below. Subsequent subsections treat organizational aspects of the selected projects and their planning for EPSDT.

A. EPSDT COORDINATORS: EDUCATION AND EMPLOYMENT STATUS ON A NATIONAL BASIS (TABLE VII)

Of the 198 projects that received a supplemental grant, 133 provided information on the background of the EPSDT coordinator. As shown in Table VII, all projects reporting indicated that their EPSDT coordinator had at least a high school education. In addition, in 9 projects, the coordinator had attended college (area of specialty unknown) and 11 projects had a coordinator who had attended graduate school.

EPSDT coordinators in 79 of the demonstration Head Start/EPSDT collaboration projects were credentialled, either as a registered nurse (56) or a licensed practical nurse (23). With respect to employment status of the EPSDT coordinators, 110 out of 133 projects indicated that their EPSDT coordinators were employed full-time. Table VII shows, however, that there is wide regional variation in the percentage of projects whose EPSDT coordinators attended college. Over half of the children actually served

EDUCATIONAL BACKGROUND AND EMPLOYMENT STATUS OF EPSDT COORDINATOR BY AGGREGATED TOTALS

TABLE VII	NATIONAL	SELECTED PROJECTS	ALL OTHER PROJECTS	REGIONS			
				I	II	III	IV
A. CHILDREN PARTICIPATING (CUMULATIVE):							
1. Total	57,133	13,259	43,874	4,566	4,882	2,810	13,247
2. Head Start	43,008	8,870	34,138	2,444	3,046	2,416	10,535
3. Non-Head Start	14,125	4,389	9,736	2,122	1,836	394	2,712
B. NUMBER OF PROJECTS:							
1. Funded	198	30	168	15	25	10	40
2. Reporting	133	24	109	11	13	6	28
C. EDUCATIONAL DEGREE/ CERTIFICATION OF EPSDT COORDINATOR:							
1. High School	133	24*	109	11	13	6	28
2. Undergraduate	95	16*	79	7	9	5	17
3. Graduate	11	1	10	1	0	1	1
4. LPN	23	2	21	3	4	0	9
5. RN	56	11	45	4	5	2	14
D. EMPLOYMENT STATUS OF EPSDT COORDINATOR:							
1. Full-Time	110	20*	90	11	10	5	26
2. Part-Time	23	4	19	0	3	1	2

*This figure does not include co-ordinators for two projects. See Table VII A

EDUCATIONAL BACKGROUND AND EMPLOYMENT STATUS OF EPSDT COORDINATOR BY AGGREGATED TOTALS

TABLE VII (Cont'd.)	REGIONS						
	V	VI	VII	VIII	IX	X	IMPD
A. CHILDREN PARTICIPATING (CUMULATIVE): 1. Total	7,240	13,426	2,145	4,674	694	3,449	1,931
2. Head Start	5,230	12,431	1,887	3,284	567	1,168	1,175
3. Non-Head Start	2,010	995	258	1,390	127	2,281	756
B. NUMBER OF PROJECTS: 1. Funded	21	26	11	10	10	12	18
2. Reporting	16	16	6	7	5	11	14
C. EDUCATIONAL DEGREE/ CERTIFICATION OF EPSDT COORDINATOR: 1. High School	16	16	6	7	5	11	14
2. Undergraduate	15	9	5	7	5	10	4
3. Graduate	6	0	0	0	1	1	0
4. LPN	1	3	0	1	1	0	3
5. RN	10	6	4	3	2	4	2
D. EMPLOYMENT STATUS OF EPSDT COORDINATOR: 1. Full-Time	10	13	6	6	5	8	10
2. Part-Time	6	3	0	1	0	3	4

were in projects where the PESDT coordinator had at least attended college. Although Table VII does not specify the number of children in each of the projects participating in the collaborative effort, a comparison of the regions indicates that in Region IV, which served approximately 23% of the children reached on a cumulative basis, 80%, or 23 out of the 38 projects reporting, employed an EPSDT coordinator who attended college.

B. EPSDT COORDINATORS: EDUCATION EXPERIENCE AND TRAINING IN SELECTED PROJECTS (Table VII-A)

In 24 out of the 25 selected projects reporting, the EPSDT coordinators had at least a high school education. Sixteen EPSDT coordinators in these projects had attended college, seven were college graduates, and one had attended graduate school. In 11 selected projects, the EPSDT coordinator was a registered nurse and, in two projects, this position was held by a licensed practical nurse. Staff paid with EPSDT funds were full-time in 20 out of 24 projects.

A large number of EPSDT coordinators had previous Head Start experience which was not health-related. In 19 out of the 24 projects reporting, the EPSDT coordinator had previously

TABLE VII-A

STAFFING: RECRUITMENT, PATTERNS, TRAINING AND TURNOVER BY SELECTED PROJECTS

SELECTED PROJECTS BY STATE	A CHILDREN PARTICIPATING (CUMULATIVE)			B Educational Degree/ Certification of EPSDT Coordinator					C Coord.'s Previous Experience		D Type of Staff Paid With EPSDT Funds, by Employment Status				E Special EPSDT Training		F Staff Turno by Reason		
	1 Total	2 HS	3 NHS	1 High School	2 Undergraduate	3 Graduate	4 LPN	5 RN	1 Years Head Start	2 Years Other Health Related	1 EPSDT Coordinator	2 Nurse	3 Health /EPSDT Aide	4 Clerk	1 Health Staff	2 Other Staff	1 Total	2 Resignation	3 Termination
OTALS FOR SELECTED PROJECTS	13,259	8,870	4,389	4=26	1=3 3=4 4=7	1=2	2	11	2=5 8=3 8 ***	3=4 4=3 2=2 4 ***	FT=17 PT=1	FT=4 PT=1	FT=10 PT=3	FT=2 PT=1	C=2 L=11 M=8 N=3	L=11 M=8 N=6	12	8	3
ACHUSETTS (I): ominster	335	264	71	4				X	8	3	FT				L	L			
rcester	743	464	279	4				X	8	3	FT	2FT	3FT**	1FT	L	L	1	1	
JERSEY (II): ms River	169	129	40	4	1					2			PT		N	N	1		1
terson	400	190	210	4	4					2	PT				M	M			
enton	384	282	102	4				X	2	3	FT		2FT		L	N			
LAND (III): ltimore	625	488	137	4	4				3½	5	FT		FT		M	M			
ISSIPPI (IV): eveland*	3,444	2,944	500	4 / 4				X /	8 / 9	15 / 15	FT / FT				M	L			
ESSEE (IV): ngston	261	167	94	4	4			X	1½		FT				C	M			
NOIS (V): ok County	906	499	407	4	4	2				4	FT				M	M			
st St. Louis	613	458	155	4	3				6						N	N	2	1	
nville	282	282	0	4	1			X	1½	4	FT		PT	PT	C	M	1	1	
(V): ncinnati	NI	NI	NI			NO INFORMATION SUBMITTED									L	L			

ODE FT = Full Time PT = Part Time W = Workshop L = Limited M = Moderate C = Considerable
N = None NI = No Information *Joint Responsibility **Social Workers ***Other

TABLE VII-A

STAFFING: RECRUITMENT, PATTERNS, TRAINING AND TURNOVER BY SELECTED PROJECTS

SELECTED PROJECTS BY STATE	A			B					C		D				E		F		
	CHILDREN PARTICIPATING (CUMULATIVE)			Educational Degree/ Certification of EPSDT Coordinator					Coord.'s Previous Experience		Type of Staff Paid With Special EPSDT Funds, by Employment Status				Special EPSDT Training		Staff Turn by Reason		
	1	2	3	1	2	3	4	5	1	2	1	2	3	4	1	2	1	2	3
	Total	HS	NHS	High School	Undergraduate	Graduate	LPN	RN	Years Head Start	Years Other Health Related	EPSDT Coordinator	Nurse	Health/EPSDT Aide	Clerk	Health Staff	Other Staff	Total	Resignation	
IO (Cont'd.) Dayton	NI	NI	NI	4	1			X	7		FT		FT		L	L	1		1
XAS (VI): Lubbock	115	112	3	4	4+				1						N	N			
Amarillo	941	896	45	4	3			X	2		FT				W	L			
Laredo (IMPD)	NI	NI	NI	4	3					4	FT	FT			L	N			
SSOURI (VII): Appleton	252	235	17	4	4				7	3	FT	FT		FT	L	L	1	1	
Springfield	621	515	106	4				X	1	12					L	L	1	1	
NTANA (VIII): Billings	167	147	20	4	3			X	9		FT	PT	2PT		L	L	2	2	
Blackfeet (IMPD)	624	174	450	4					2		FT				L	L			
Fort Peck (IMPD)	344	344	0	4					2	7	FT				L	N			
LIFORNIA (IX): El Centro	NI	NI	NI	4	2		X		3	6	FT		FT		M	M	1		1
Fresno	NI	NI	NI	4			X			20					M	L			
EGON (X): Eugene*	229	128	101	4/4	4/4				2/2				FT		M	M			
Medford	1,802	152	1,650	4	2			X	3	1			FT		M	M	1	1	

CODE

FT = Full Time
PT = Part Time
W = Workshop

L = Limited
M = Moderate
C = Considerable

N = None NI = No Information *Joint Responsibility worked in Head Start. A majority, 12 out of 21 such personnel,* had less than five years prior Head Start experience. But, in 16 out of the 24 projects reporting, the EPSDT coordinator had other health related experience. Of the personnel involved, 10 out of 16 had less than five years of health related experience.

A majority of the selected projects, 16 out of 24, used their supplemental grants to employ full-time EPSDT coordinators. Exceptions to this pattern included one project, Cleveland, Mississippi, which employed two full-time coordinators, and one project in which only a part-time staff person was paid with EPSDT funds. In addition, 10 projects used their grant to employ other staff on a full-time basis. For example, three out of four projects in this group employed full-time nurses and seven out of 10 hired full-time health/EPSDT aides. In other instances, nursing and paraprofessional staff who were paid with supplemental grant funds were part-time. The Worcester, Mass., project used the EPSDT grant to maintain staff, including social service workers during the summer months to assist in outreach and recruitment. Clerical staff was less commonly employed. Only three projects used supplemental grant monies to hire clerks. Table VII-A also does not indicate whether grant monies fully covered or only supplemented salaries.

It should be noted that other Head Start staff, whose salaries were not paid in full or in part by the EPSDT grant, were often involved in the collaborative effort. The on-site visits indicated that center directors and family service staff were in many instances continually engaged in various activities essential to the collaborative effort; e.g., negotiating for EPSDT services to be available to their project or recruiting through the Parent Involvement Component.

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*Of the 19 projects, two projects reported that responsibility for EPSDT was shared; thus the total staff involved is 21.

12 selected projects experienced staff turnover of the staff paid for by the EPSDT supplemental grant. Two projects lost two staff members either through resignation or transfer to another position in the Head Start program and 8 projects lost one member. The major reason for staff turnover as cited by the projects was resignation in 8 out of 12 cases.

Center health staff had received special EPSDT training in 88% of the selected projects and only 76% of other staff had received training, usually through the efforts of the EPSDT coordinator, and was limited in amount. In those projects where the health staff had received special EPSDT training, it consisted only of OCD workshops and of possibly one state or local training session (limited); in eight cases, it involved additional sessions under various auspices (moderate); in two cases, it consisted of a large number of training opportunities (considerable). No staff member, health or other, had received special EPSDT training in three projects. There was some variation among selected projects regarding the proportion of health staff as compared to other staff who received special EPSDT training, as also shown in Table VII-A.

Data on the cumulative number of children served was reported by 20 out of the 25 selected projects. Approximately 50% of the children in these programs had EPSDT coordinators who attended college. This figure is somewhat skewed in that one project, Cleveland, Mississippi, served 26% of the 13,259 children in the selected projects. 7,178 children, about 48% of whom were in the Cleveland, Mississippi project, were served by EPSDT coordinators who were credentialled registered nurses.

A majority of children (88%) were in projects where the EPSDT coordinator had prior experience in Head Start and 77% of the children had coordinators who had other health related experience. 70% of the children were served by EPSDT coordinators who worked on a full-time basis.

Only 995 children were served by full-time nurses who were paid by the EPSDT supplemental grant, and only 33% of the children were in projects where the grant had been used to employ health/EPSDT aides. A majority of the children, 63%, however, were in projects where the EPSDT coordinator had received moderate or considerable training.

C. CONCLUSIONS ON ORGANIZATION AND OPERATION OF EPSDT

1. All the selected projects had designated as EPSDT coordinator a person who had at least high school training. Relatively less projects in the EPSDT effort involved EPSDT coordinators who had attended college and graduate school.

2. The majority of EPSDT coordinators had previous experience in Head Start and, since many of the projects reported that their EPSDT coordinator was full-time, the supplemental grant may have been used in many instances to augment the salaries of existing staff.

3. Because of the limitations of the supplemental grant and the need for additional staff resources to implement the demonstration program, some projects had to utilize the non-EPSDT paid Head Start personnel to carry out certain functions.

4. Training of health and other staff for the EPSDT effort was generally limited and consisted primarily of OCD workshops.

D. RECOMMENDATIONS ON ORGANIZATION AND OPERATION OF EPSDT

1. Training of the Head Start staff, particularly those members who have direct responsibility for the operation of the EPSDT collaborative effort, is crucial, in order that the demonstration objectives are understood and clarified.

2. Such training should place specific emphasis upon ways in which all Head Start staff can support the collaborative effort as they perform their regular duties.

3. Familiarity with Head Start program objectives and health-related matters should enhance the capability of the EPSDT coordinator to provide an effective leadership and training role in implementing the EPSDT demonstration effort. Therefore, Head Start programs should be encouraged to recruit and hire persons with this specific background to be responsible for coordinating these services. Moreover, this position should be full-time and under the supervision of the health services coordinator to insure full integration of the EPSDT effort into the overall Head Start health program.

A. EPSDT COORDINATOR: AWARENESS OF EPSDT (Table VIII)

Coordinators and other involved staff in the 25 selected projects had varying degrees of awareness, or basic knowledge about EPSDT and its provisions. Basic knowledge about EPSDT informational sources is shown in Table VIII.

B. ANALYSIS OF FINDINGS: AWARENESS OF EPSDT

In most of the selected projects (22), the coordinators knew of the existence of the State EPSDT Plan. However, of this group, only 15 had a copy of the State Plan. In one project, this copy was determined to be out-of-date. Two coordinators indicated that they had descriptive materials on the state EPSDT program but they were uncertain whether these materials actually constituted the state plan.

Whether the selected project staff had a copy of the State Plan or not, they tended to have little knowledge about the more technical aspects of the EPSDT program. For instance, in 19 out of 25 projects, staff knew the eligibility requirements for children and families to participate in the EPSDT program, but only 13 knew the step-by-step certification procedures. Staff in 15 projects were aware of the rates for reimburseable EPSDT services, but this may have been a result of activities associated with obtaining specific EPSDT services, including feedback from providers.

TABLE VIII

HEAD START/EPSDT SELECTED PROJECTS' KNOWLEDGE OF STATE EPSDT PLAN

SELECTED PROJECTS BY STATE	A					B				C					
	POSSESSION OF COPY OF STATE EPSDT PLAN					KNOWLEDGE OF:				SOURCE OF KNOWLEDGE					
	1	2	3	4	5	1	2	3	4	1	2	3	4	5	6
	Current	Out-of-Date	None	Uncertain	Not Applicable	State EPSDT Plan Existence	Eligibility Requirements	Certification Procedures	Rates for Reimbursable EPSDT Services	OCD Workshops	Own Initiative	Health Liaison Specialist	Local Welfare	State Welfare	Providers
ASSACHUSETTS (I): Leominster			X			Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Ye
Worcester				X		Yes	Yes	No	No	Yes	Yes	Yes	No	No	No
EW JERSEY (II): Toms River			X			No	No	No	No	No	Yes	No	No	Yes	No
Paterson		X				Yes	Yes	No	Yes	No	Yes	No	No	No	Ye
Trenton	X					Yes	Yes	No	No	Yes	Yes	No	No	No	No
ARYLAND (III): Baltimore	X					Yes	Yes	Yes	No	No	Yes	No	Yes	Yes	No
ISSISSIPPI (IV): Cleveland	X					Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No
ENNESSEE (IV): Kingston	X					Yes	Yes	Unc	Yes	Yes	Yes	Yes	Yes	Yes	No
LLINOIS (V): Cook County	X					Yes	Yes	No	No	Yes	Yes	Yes	Yes	No	No
East St. Louis	X					Yes	No	Yes	Yes	Yes	No	No	No	No	No
Danville	X					Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No
HIO (V): Cincinnati			X			Yes	Yes	No	Yes	Yes	Yes	No	No	No	Ye
Dayton	X					Yes	No	No	Yes	No	Yes	No	No	No	Ye

CODE:
Y = Yes
N = No
UNC = Unclear

TABLE VIII

HEAD START/EPSDT SELECTED PROJECTS' KNOWLEDGE OF STATE EPSDT PLAN

SELECTED PROJECTS BY STATE	A					B				C					
	POSSESSION OF COPY OF STATE EPSDT PLAN					KNOWLEDGE OF:				SOURCE OF KNOWLEDGE					
	1	2	3	4	5	1	2	3	4	1	2	3	4	5	
	Current	Out-of-Date	None	Uncertain	Not Applicable	State EPSDT Plan Existence	Eligibility Requirements	Certification Procedures	Rates for Reimbursable EPSDT Services	OCD Workshops	Own Initiative	Health Liaison Specialist	Local Welfare	State Welfare	
XAS (VI): Lubbock			X			Yes	No	No	No	Yes	Unc	Yes	NA	Yes	U
Amarillo	X					Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA	Yes	U
Laredo (IMPD)	X					Yes	Yes	No	Yes	Yes	Yes	Yes	NA	Yes	Y
SSOURI (VII): Appleton	X					Yes	No	No	Unc	Yes	Yes	Yes	Yes	Yes	
Springfield			X			No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	N
NTANA (VIII): Billings			X			Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Y
Blackfeet (IMPD)			X			Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	N
Fort Peck (IMPD)			X			Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	Y
LIFORNIA (IX): El Centro				X		No	No*	Yes*	No	Yes	Yes	No	No	No	N
Fresno	X					Yes	Yes	Yes	Unc	Yes	Yes	Yes	No	Yes	Y
EGON (X): Eugene	X					Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Y
Medford	X					Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Y
Total Selected Projects	14	1	8	2	0	22-Y 3-N	19-Y 6-N	13-Y 11-N	15-Y 8-N	19-Y 6-N	23-Y 1-N	14-Y 11-N	8-Y 14-N	14-Y 11-N	10 13
								1-Unc	2-Unc		1-Unc		3-NA		2-

roblems with local welfare release information and imposition of litional requirements.

CODE:
Y = Yes
N = No
UNC = Unclear

A large majority of the staff in 23 of the 25 selected projects relied upon their own initiative to obtain information about the state EPSDT program. Nineteen coordinators did state, however, that they had also learned of the program through the OCD Regional Training Workshops. In addition, 14 projects cited the health liaison specialist as another source of basic knowledge about the state EPSDT program.

Less than 50% of the projects indicated that the state or local Medicaid/EPSDT agency or providers of service were sources of basic knowledge about the program. Of particular importance is the fact that the state rather than the local Medicaid/EPSDT agency proved to be a greater source of knowledge (14 out of 25 projects reporting a state agency as a source, compared to 8 out of 25 reporting a local agency as a source). This may be attributed to the fact that the state agency was the unit most responsible for the preparation and dissemination of information about the availability of the EPSDT program.

C. CONCLUSIONS ON AWARENESS OF EPSDT

> Head Start program staff had to rely, to a great degree, upon their own resources to obtain information about the State EPSDT program. Governmental agencies proved to be less reliable in this regard. On the other hand, knowledge about the EPSDT program among Head Start personnel tended to be general rather than specific, thereby limiting their ability to effect changes in the institutional arrangements of the program.

A. ORGANIZATIONAL LOCATION, EPSDT PLAN AND SUPPORTIVE SERVICES FOR SELECTED PROJECTS (Table IX).

Table IX outlines the organizational structure of the respective demonstration projects through the use of various codes described within the table. The table also provides information on the type of planning that was utilized by the projects for the implementation of the collaborative effort. Further, it indicated the type of supportive services which were rendered by provider to non-Head Start children.

B. ANALYSIS OF FINDINGS

1. Organizational Affiliation of Selected Projects (Table IX)

The 25 selected projects were primarily located within the community action agencies. An overwhelming majority--17--shared this location. Of the remaining projects, four were located within a public agency, three were sponsored by school systems and one by a voluntary agency. The location of one program changed during the course of the year from a community action agency to a school system.

2. Planning for Collaborative Effort

A majority of programs--14--considered their supplementary grant proposals to be their EPSDT service plans. Two projects developed more detailed plans. OCD had originally required submission of a questionnaire and workbook proposal by all potential grantees. These provided background data on the projects as well as an outline of how the demonstration collaborative effort would be organized and operated.

Elements described included:

- proposed management and organization
- potential and planned numbers of Head Start and non-Head Start children to be served in terms of children eligible and certified for Medicaid
- need in terms of gaps and problems with existing health service delivery systems
- arrangements for involving or relating to health service agencies, providers, and other important resources such as welfare, children's services, etc.
- proposed budget.

Although all projects that were selected for demonstration funding had to submit a questionnaire or workbook proposal, nine projects did not consider these materials a service plan as reflected in the opinions of EPSDT coordinators, health service coordinators and/or Head Start directors. In four instances, as shown in the table, these projects managed their collaborative effort through other means. Site visits indicated that these alternatives included the project's health service plan, informal coordination between the director and health services coordinator, etc. Five projects did not feel that they had a plan. The reasons for this situation ranged from the feeling that a demonstration effort should not be planned but permitted to develop, to the position that the workbook did not really entail any commitment by the projects.

Even where projects consider the questionnaire and workbook to constitute a service plan, they often did not feel bound by their proposed service goals or approaches, particularly with respect to non-Head Start children. Various factors underlay this attitude including:

- subsequent confusion as to the necessity and desirability of serving non-Head Start children
- supplemental grants substantially less than requested
- unrealistic estimates of the time and effort required to establish relationships with other resources
- imposition of additional administrative requirements by OCD, i.e., the evaluation and completion of the associated forms.

3. Provisions for Supportive Services (Table IX)

Both Medicaid and Head Start are obligated to provide supportive services for non-Head Start children under the collaborative effort. These services are described in this section. However, supportive services for Head Start children are not described because:

- Head Start provided such services before the initiation of the collaborative effort
- already existing provisions for supportive services--overwhelmingly based on direct provisions--were not altered under the collaborative effort.

In those instances where a project made minimal efforts to recruit and serve non-Head Start children and, therefore had little knowledge of alternative providers, a "None" is entered in Table IX. Note that "None" does not necessarily imply that a specific supportive service is not available. This situation occurred in the case of Worcester, Danville, and Amarillo. In other instances, a "None" indicates that a service was not provided to non-Head Start children.

Supportive services are described by the following categories:

- Outreach: Identification/Recruitment; Publicity; and Certification
- Transportation
- Babysitting
- Follow-up: Tracking; Verification, Recordkeeping/ Record Disposition.
- Follow-up: Tracking; Verification, Recordkeeping/ Record Disposition

The Head Start projects were the major providers of supportive services for non-Head Start children. 21 out of the 25 selected projects reported that they provided a variety of supportive services to this group and in 8 instances Head Start was the sole provider of supportive services. The supportive services most usually provided by the Head Start project included publicity, tracking and verification. The provision of certification and recordkeeping/record disposition was the second most frequently reported services provided by Head Start.

The next most prominent type of provider arrangement consisted of joint efforts by Head Start and public health and/or welfare agency. This arrangement was used for identification in seven out of 25, or 28%, of the projects, for certification in six of 25 cases, and with decreasing frequency for providing tracking, verification, publicity, and transportation. Unlike the other projects, in Eugene, the Head Start project and the public agency both provided all the supportive services except for babysitting which was provided by the Head Start project only.

In some instances where joint efforts were reported, the Head Start projects concentrated their supportive services on the siblings of Head Start enrollees or non-Medicaid certified children while the public agency focused upon the Medicaid eligible population which tended to be Head Start children. In other instances, the Head Start project performed some aspect of tracking not done by the public agency.

The supportive services provided by public agencies were primarily in the area of follow-up, although only in a significant minority of cases, i.e., 20% across the three follow-up services--tracking, verification, recordkeeping/record disposition. This would suggest that the public agency as a rule was less concerned with recruiting new participants into the EPSDT program as they were in following up on those children already enrolled.

There was minimal involvement of voluntary agencies either as sole providers or in concert with other agencies, such as Head Start. A voluntary agency provided babysitting services in one case. Some voluntary agencies cooperated with Head Start in providing publicity and transportation. The relatively low level of involvement of the voluntary sector is probably attributable to:

- perceived level of program agency effort required for solicitation of voluntary agency
- lack of voluntary agency resources and/or knowledge to support involvement

The least frequently provided supportive services to non-Head Start children was babysitting. Undoubtedly this is a reflection of the lack of available resources, i.e., additional funds.

C. CONCLUSIONS: PLANNING FOR COLLABORATIVE EFFORT

1. Many projects that had been selected for the EPSDT demonstration effort had initiated little planning for implementing the program.
2. Lack of clarity about demonstration objectives, insufficient staff time augmented by relatively low supplemental grants to hire personnel, served to create a climate of confusion and resistance in the projects which hampered their ability to plan effectively.
3. Many projects were unaware of the administrative detail, including the imposition of evaluative procedures, and these additional duties may have overburdened already limited staff resources.

D. RECOMMENDATIONS: PLANNING FOR COLLABORATIVE EFFORT

1. OCD should initiate a systematic and detailed planning process for the implementation of the EPSDT collaborative effort. Such planning should include clarification of objectives, techniques for needs assessment, and surveys of community resources. Also, OCD should insure that the demonstration projects have, in hand, information about the provision and availability of EPSDT services in their area.
2. Head Start projects should be assisted in developing skills that will enhance their ability to make greater use of their existing staff by employing time utilization and manpower development procedures.

E. CONCLUSIONS : SUPPORTIVE SERVICES EPSDT

1. The Head Start projects were the major provider of supportive services to non-Head Start children which suggests that there was a general appreciation of the requirement and intent of the EPSDT collaborative effort.

2. Public agencies tended to focus their supportive services on follow-up rather than outreach activities. The voluntary sector proved to be of little resource to the Head Start project in providing supportive services.

F. RECOMMENDATIONS: SUPPORTIVE SERVICES EPSDT

1. Specific attention should be given to developing ways in which Head Start and public agencies can work jointly in providing supportive services to non-Head Start children so that their efforts are better coordinated.

2. The Head Start programs should pursue arrangements for reimbursement of those supportive services provided they are part of State EPSDT Plan.

3. Head Start programs should realize resources that may be available in the voluntary sector, particularly in the area of outreach.

4. Comprehensive health services for low-income preschool children should include provision for baby-sitting services in order to insure that families will take advantage of the program.

TABLE IX

HEAD START PROGRAM: ORGANIZATIONAL LOCATION, EPSDT PLAN AND SUPPORTIVE SERVICES BY PROVIDER, FOR SELECTED PROJECTS

SELECTED PROJECTS BY STATE	A	B				C								
	ORGANIZATIONAL LOCATION OF HEAD START PROGRAM	TYPE OF EPSDT SERVICE PLAN				SUPPORTIVE SERVICES FOR NON-HEAD START CHILDREN BY PROVIDER*								
		1	2	3	4	1	2	3	4	5	6	7	8	9
						OUTREACH					FOLLOW-UP			
		Workbook Proposal and Questionnaire	Additional Written Plan	Other	None	Identification/ Recruitment	Publicity	Certification	Transportation	Babysitting	Tracking	Verification	Recordkeeping/ Record Disposition	Health Education
MASSACHUSETTS (I): Leominster	CAA	X				HS	HS VA+PA	HS	HS+VA	HS	HS	HS	HS	
Worcester	School System	X				N	N	N	N	N	N	N	N	
NEW JERSEY (II): Toms River	CAA				X	HS	HS	HS	HS	VA	N	N	N	
Paterson	CAA			X		HS	HS	HS	HS	N	HS	HS	HS	
Trenton	CAA	X				HS	HS	PA	HS	N	HS	HS	HS	
MARYLAND (III): Baltimore	PA			X		HS+PA	HS	PA	PA	N	PA	PA	PA	
MISSISSIPPI (IV): Cleveland	CAA					HS	HS	HS	HS	HS	HS	HS	HS	
TENNESSEE (IV): Kingston	School System	X				HS	HS	HS	N	N	HS	HS	HS	
ILLINOIS (V): Cook County	CAA	X				N	HS	HS	N	N	HS	HS	HS	
East St. Louis	CAA					N	HS	HS	HS	N	HS	HS	HS	
Danville	CAA					N	N	N	N	N	N	N	N	
OHIO (V): Cincinnati	CAA			X		HS	HS	HS	HS	N	HS	HS	HS	
Dayton	CAA				X	N	N	N	HS	N	HS	HS	N	

*Head Start children not included because it is assumed that supportive services are provided by HS as necessary.

CODE:
HS = Head Start
VA = Voluntary Ager
PA = Public Agency
N = None

TABLE IX

HEAD START PROGRAM: ORGANIZATIONAL LOCATION, EPSDT PLAN AND SUPPORTIVE SERVICES BY PROVIDER, FOR SELECTED PROJECTS

	A	B				C								
SELECTED PROJECTS BY STATE	ORGANIZATIONAL LOCATION OF HEAD START PROGRAM	TYPE OF EPSDT SERVICE PLAN				SUPPORTIVE SERVICES FOR NON-HEAD START CHILDREN BY PROVIDER*								
		1	2	3	4	1	2	3	4	5	6	7	8	9
						OUTREACH					FOLLOW-UP			
		Workbook Proposal and Questionnaire	Additional Written Plan	Other	None	Identification/ Recruitment	Publicity	Certification	Transportation	Babysitting	Tracking	Verification	Recordkeeping/ Record Disposition	Health Education
TEXAS (VI): Lubbock	CAA	X			X	HS	N	N	HS	HS	HS	PA	N	
Amarillo	CAA				X	N	N	N	N	N	N	N	N	
Laredo (IMPD)	School System	X				HS+PA	HS	HS	HS	N	HS	HS	HS	
MISSOURI (VII): Appleton	CAA			X		HS+PA	HS	HS	HS	HS	HS	HS	HS	
Springfield	CAA	X				HS	HS	HS	HS	N	HS	HS	HS	
MONTANA (VIII): Billings	PA				X	HS+PA	HS	HS+PA	PA	HS	PA	PA	PA	
Blackfeet (IMPD)	CAA		X			HS+PA	HS	HS+PA	PA	N	PA	PA	PA	
Fort Peck (IMPD)	CAA	X				HS+PA	HS	HS+PA	HS	N	PA	PA	PA	
CALIFORNIA (IX): El Centro	CAA		X			HS	HS+PA	HS	HS	HS	HS	HS	HS	
Fresno (IMPD)	Autonomous	X				HS	HS	HS+PA	HS	HS	HS	HS	HS	
OREGON (X): Eugene	PA	X				HS+PA	HS+PA	HS+PA	HS+PA	HS	HS+PA	HS+PA	PA	
Medford	PA				X	PA	HS+PA	HS+PA	N	HS	HS	HS	PA	

*Head Start children not included because it is assumed that supportive services are provided by HS as necessary.

CODE:
HS = Head Start
PA = Public Agency
CAA = Community Action Agency
VA = Voluntary Agenc
N = None

A. ARRANGEMENTS FOR PROVISION OF HEALTH SERVICES (TABLE IX-A)

One objective of the Head Start/EPSDT Collaborative Effort was to supplant Head Start provision of health services which Head Start provides either directly or through reimbursed or contributing health practitioners. The goal was to make greater use of Medicaid reimbursement to practitioners or directly to the program, by treating the program as vendor. The arrangements made by the 25 selected demonstration projects to provide screening and treatment services to Head Start and non-Head Start children are presented in Table IX-A.

The classifications of providers used in the analysis are as follows:

.	Vendor (V)	The single practitioner or group receiving Medicaid reimbursement, e.g., clinic, or hospital out-patient department.
.	Provider (P):	The single practitioner or group not receiving Medicaid reimbursement, usually entities such as the Indian Health Service, school districts, student staffed operations.
.	Head Start Vendor (HS/V):	Direct operation of services by a program for which it receives Medicaid reimbursement under a vendor number.
.	Head Start Provider (HS/P):	Direct operation of service by a program for which it does not receive reimbursement.

HEAD START EPSDT HEALTH SERVICES PLAN: HEALTH SERVICES FOR HEAD START AND NON-HEAD START CHILDREN BY PROVIDER ARRANGEMENT

TABLE IX-A	TOTAL SELECTED PROJECTS	MASS. (I)		NEW JERSEY (II)			MD. (III)	MISS. (IV)	TENN. (IV)	ILLINOIS (V)			OHIO (V)	
		Leominster	Worcester	Toms River	Paterson	Trenton	Baltimore	Cleveland	Kingston	Cook County	East St. Louis	Danville	Cincinnati	Dayton
HEAD START CHILDREN														
A. SCREENING:														
1. Physical Exam		V	V	V+P	V	V	V+P	MV + V+HS/P	V	V	V	V	V	V
2. Immunization		V	V+HSP	HS/P	HS/P	V	V+P	V	MV + HS/P	V	V	V	V	V
3. Speech		HS/P	HS/P	V	V	V	V+P	P	HS/P	P	V	V	V	V
4. Hearing		HS/P	HS/P	V+P	V	V	V	HS/P	MV + HS/P	P	V	HS/P	V	V
5. Vision		HS/P	HS/P	V+P	V	V	V+P	HS/P	MV + HS/P	V	V	HS/P	V	V
6. Dental		V	HS/P	P	V	V	V+P	V	V	V	V	V	V+P	V
7. Mental Health		HS/P	NI	V	V	P	V+P	P	V	P	V	HS/P	M	V
8. Nutritional		HS/P	HS/P	HS/P	V+HS/P	V	V+P	HS/P	HS/P	V	V	HS/P	HS/P	V
B. TREATMENT:														
1. Medical		V	V	V	V+P	V	V+P	V	V	V	V	V	V	V
2. Dental		V	V	V	V+P	V	V+P	V	V	V	V	V	V	V
3. Mental Health		P	V	V	V	P	V+P	P	V	P	V	V	V	V
4. Nutritional		V	V	HS/P	V	V	V+P	HS/P	HS/P	HS/P	V	V	HS/P	V
NON-HEAD START CHILDREN														
A. SCREENING:														
1. Physical Exam		V	NA	V	V	V	V	V	V	V	V	NA	V	V
2. Immunization		V	NA	HS/P	V	V	V	V	V	V	V	NA	V	V
3. Speech		HS/P	NA	V	V	V	V	P	V	P	V	NA	V	V
4. Hearing		HS/P	NA	V+P	V	V	V	V	V	P	V	NA	V	V
5. Vision		HS/P	NA	P	V	V	V	V	V	V	V	NA	V	V
6. Dental		V	NA	V	V	NA	V	V	V	V	V	NA	V	V
7. Mental Health		HS/P	NA	V	V	P	V	P	V	P	V	NA	V	V
8. Nutritional		HS/P	NA	V+HS/P	V	V	V	HS/P	HS/P	V	V	NA	HS/P	V
B. TREATMENT:														
1. Medical		V	NA	V	V	V	V	V	V	V	V	NA	V	V
2. Dental		V	NA	V	V	NA	V	V	V	V	V	NA	V	V
3. Mental Health		P	NA	V	V	P	V	P	V	P	V	NA	V	V
4. Nutritional		V	NA	V+HS/P	V+HS/P	V	V	HS/P	HS/P	HS/P	V	NA	HS/P	V

CODE:

V = Vendor HS/V = Head Start/Vendor
P = Non-Vendor Provider HS/P = Head Start/Non-Vendor Provider
N = No Provider
NA = Not Applicable
M = Medicaid Eligible Only
NI = No Information

HEAD START EPSDT HEALTH SERVICES PLAN: HEALTH SERVICES FOR HEAD START AND NON-START CHILDREN BY PROVIDER ARRANGEMENT

TABLE IX-A	TEXAS (VI)			MISSOURI (VII)		MONTANA (V III)			CALIFORNIA (IX)		OREGON (X)			
	Lubbock	Amarillo	Laredo (IMPD)	Appleton	Spring-field	Billings	Blackfeet (IMPD)	Fort Peck (IMPD)	El Centro	Fresno (IMPD)	Eugene	Medford		
HEAD START CHILDREN A. SCREENING:														
1. Physical Exam	MV + P	V	V	V	V	V + P	V + P	V + P	V+HS/P	V + P + HS/P	V + HS/V	V		
2. Immunization	MV + P	V	V	HS/P	MV + V + HS/P	V + P	V + P	V + P	P	V + P	V + HS/V	V		
3. Speech	MV + P	V	V + P	HS/P	P	HS/P	V + P	V + P	HS/P	V + P	V + HS/V	P + HS/P		
4. Hearing	MV + P	V+HS/P	V + P	P	P	HS/P	V + P	V + P	HS/P	V + P	V + HS/V	P		
5. Vision	MV + P	V+HS/P	V + P	P	HS/P	HS/P	V + P	V + P	HS/P	V + P	V + HS/V	P + HS/P		
6. Dental	MV + P	V	V	V	V	V	V + P	V + P	V	V + P	V + HS/V	V		
7. Mental Health	NI	V	NA	V	P	HS/P	V + P	V + P	HS/P	V + P	V + HS/V	HS/P		
8. Nutritional	MV + P	V	V	V+HS/P	HS/P	HS/P· P	P	P	HS/P	V + P	P + HS/V	P + HS/P		
B. TREATMENT:														
1. Medical	MV + P	V	V	V	V	V	V + P	V + P	V	V + P	V	V		
2. Dental	MV + P	V	V	V	V	V	V + P	V + P	V	V+P + HS/P	V + HS/P	V		
3. Mental Health	NI	V	V	V+HS/P	P	V	V + P	V + P	V	V + P	V	P		
4. Nutritional	MV + P	V	V	V+HS/P	HS/P	P	P	NA	V + P	V + P	HS/P	P		
NON-HEAD START CHILDREN A. SCREENING:														
1. Physical Exam	NA	NA	V	V	V	V	V	V	V	V+P + HS/P	V	V		
2. Immunization	NA	NA	V	V	V	V	V	V	HS/P	V + P	V	V		
3. Speech	NA	NA	V	V	V	V	V	V	HS/P	V + P	V	V		
4. Hearing	NA	NA	V	V	V	V	V	V	HS/P	V + P	V	V		
5. Vision	NA	NA	V	V	V	V	V	V	HS/P	V+P + HS/P	V	V		
6. Dental	NA	NA	V	V	V	V	V	V	V	V+P + HS/P	V + HS/V	V		
7. Mental Health	NA	NA	V	V	V	V	V	V	HS/P	V + P	V	V		
8. Nutritional	NA	NA	NA	V	P	N	P	P	HS/P	V + P	HS/P	P + HS/P		
B. TREATMENT:														
1. Medical	NA	NA	V	V	HS/P	V	V + P	V + P	V	V + P	V	V		
2. Dental	NA	NA	V	V	V	V	V + P	V + P	V	V+P + HS/P	V + HS/V	V		
3. Mental Health	NA	NA	NA	V	P	V	V + P	V + P	V	V + P	V	P		
4. Nutritional	NA	NA	V	V	V	NA	NA	NA	V	V + P	P	N		

Code:

V = Vendor HS/V = Head Start/Vendor
P = Non-Vendor Provider HS/P = Head Start/Non-Vendor Provider
N = No Provider
NA = Not Available
M = Medicaid Eligible Only
NI = No Information

- No Provider (N): Absence of any provider within the project's adjacent area.
- Medicaid Eligible Only (M): Children in this status received services from the provider indicated --usually a vendor--whereas alternative arrangements were made for all other children.
- Not Applicable (NA): Services were not provided because (1) the children were too young to benefit or (2) they were not encompassed in the state EPSDT plan.

B. ANALYSIS OF FINDINGS ON ARRANGEMENTS FOR PROVISION OF HEALTH SERVICES

Overall, the table reflects three noteworthy patterns in the provider arrangements made by the selected projects for EPSDT service:

1. Heavy reliance on vendors (those providers recognized as vendors of health service by Medicaid) to serve both Head Start and non-Head Start children; but particularly the latter. Vendors predominate in nine out of 12 service categories.
2. Use of variety of arrangements involving more than one type of provider, particularly in the case of Head Start children, with vendor and provider being a prevailing combination although never the predominant arrangement. Other arrangements include:
   - vendor and Head Start provider (12 instances in 9 service categories)
   - vendor, provider, and Head Start provider (8 instances in 5 categories)

- vendor and Head Start vendor (9 instances in 9 categories in one project, i.e., Eugene, Oregon)
- vendor as provider for Medicaid eligible children only, Plus vendor and Head Start provider (one instance in each of two categories)
- vendor as provider for Medicaid eligible children only, plus Head Start provider (one instance in each of two categories)
- vendor as provider for Medicaid eligible children only, plus provider (10 instances in as many categories)
- vendor as provider for Medicaid eligible children only, plus Head Start provider (three instances in as many categories)
- provider, plus Head Start as provider (six instances in five categories) or vendor (one instance).

3. Provision of services were more available to Head Start children than to non-Head Start children. There were only three instances in two categories in which services were unavailable to Head Start children as compared to four to six instances in each category for non-Head Start children.

There were only two instances in which there was no provider, i.e., nutritional screening for non-Head Start children in Billings, Montana and nutritional services for these children in Medford, Oregon.

Only one of the selected Head Start projects (Eugene) is an EPSDT vendor. This project, which had its vendor status prior to the collaborative effort, continued to use other vendors so as to accomodate present requests and to minimize practitioner opposition. A second selected project--Springfield, Missouri-- is scheduled to receive a joint vendor number with a private practitioner in the near future. Plans to achieve such status had been initiated prior to the collaborative effort.

Head Start projects served as providers across all screening categories as well as for dental, mental health, and nutritional treatment services for Head Start children, i.e., not at all in the case of dental screening or dental and mental health treatment and with less frequency in other categories.

Head Start as the sole provider was the most predominant arrangement in the case of nutritional screening for Head Start children (9 out of 25 projects, with vendors being the second most prevalent in 7 projects). Head Start is the second most prevalent provider for nutritional services. This arrangement also prevails in the case of non-Head Start children, although the frequency is not as great.

Head Start provided services for the four screening categories, i.e., speech, hearing, vision and mental health, in the case of both Head Start and non-Head Start children but with greater reliance on providers than in other categories. This pattern is more prevalent, however, in the case of Head Start children.

C. CONCLUSIONS ON ARRANGEMENTS FOR PROVISION OF HEALTH SERVICES

1. Various factors underlie the pattern of Head Start as provider, including the lack of alternative community resources and the difficulties entailed in obtaining the cooperation of private practitioners. This situation confronts projects particularly in areas where there are minimal health services. The resistance of general health practitioners to fine-detail screening, because of the time and effort entailed, as well as their perception of minimal benefits to be gained are also factors cited by a number of selected projects. Head Start became a provider, and remains one, to offset these circumstances.

2. Because of these factors, there was a tendency to place greater reliance on providers, probably reflecting either the prevalence of specialists in these fields who are not vendors, or the prevalence of resources within institutional entities which are not vendors, e.g., school districts, student-staffed clinics, etc.

3. Head Start projects tended to rely on proven resources rather than attempt to identify new resources. At least in some projects, non-Head Start children were served by vendors, whereas Head Start children were served by the project itself or another provider. Some of the projects indicated,however, that they questioned the screening received from vendors but did not have the resources to bring all children within the gamut of their preferred approach to provider arrangements for fine-detail screening.

   An interesting pattern is presented in the case selected IMPD projects--reliance on a combination of vendors and providers. In the case of the Indian projects, this tendency reflects the important role of the Indian Health Service; whereas in the case of Fresno, it reflects the availability of migrant health program resources.

4. Overall, provider arrangements for the Head Start/ EPSDT effort were dominated by vendors, but Head Start as a non-reimbursed direct provider, and other providers, continued to play an important

role. Vendors were particularly predominant in the case of non-Head Start children for whom services were more likely not to be applicable.

D. RECOMMENDATIONS ON ARRANGEMENTS FOR PROVISION OF HEALTH SERVICES

1. Head Start programs should be provided specific assistance for pursuing strategies to obtain reimbursement for special services which they provide which can be paid by the EPSDT program.
2. Head Start programs should be encouraged to utilize public health resources in their community as a means of offsetting the limitations of the EPSDT program.
3. The success/failure of the EPSDT program rests quite clearly on the accessibility and availability of a full range of health services. Therefore, OCD should work very closely with SRS to strengthen the legislative and regulatory basis for the program as the first step in bringing about a more equitable allocation of local health resources.

A. OPERATION OF OUTREACH (Table IX-B)

The selected projects used a variety of outreach methods to recruit non-Head Start children into the EPSDT collaborative effort. The variables used to describe outreach operations included:

- cumulative participation
- number and percent of siblings of Head Start children certified prior to the program
- identification of projects in which non-English speaking non-Head Start children participated
- frequency of use of particular outreach methods such as: mass media, literature, Parent Involvement Component, door-to-door contact, telephone, letters, etc.; frequency includes instances of use of bilingual methods and perceived effectiveness of outreach methods
- indicators of outreach effectiveness for both Head Start and non-Head Start populations reflecting members of medicaid certification that occurred during the year (cumulative certification minus prior certification as described in the forms).

The indicator of outreach effectiveness is particularly useful in measuring outreach to Head Start children, since these children were reached within the context of overall Head Start Performance Standards and enrollment guidelines. As noted previously, the Head Start recruitment guidelines often differ from state guidelines in respect to Medicaid eligibility based on income level.

OUTREACH BY SELECTED PROJECTS

TABLE IX-B	NATIONAL TOTALS	MASS. (I)		NEW JERSEY (II)			MD. (III)	MISS.(IV)	TENN.(IV)	ILLINOIS (V)			OHIO (V)	
		Leominster	Worcester	Toms River	Paterson	Trenton	Baltimore	Cleveland	Kingston	Cook County	East St. Louis	Danville	Cincinnati	Dayton
A. CHILDREN PARTICIPATING (CUMULATIVE): 1. Total	13,259	335	743	169	400	384	625	3,444	261	906	613	282	NI	NI
2. Head Start	8,870	264	464	129	190	282	488	2,944	167	499	458	282	NI	NI
3. Non-Head Start	4,389	71	279	40	210	102	137	500	94	407	155	0	NI	NI
B. SIBLINGS AMONG NON-HEAD START CHILDREN: 1. Number	877	1	0	0	152	82	4	NI	64	1	143	0	NI	9
2. Per cent	81	50	92	0	100	99	5	NI	100	33	95	0	NI	56
C. NO. OF NON-HEAD START CHILDREN CERTIFIED PRIOR TO PROGRAM	711	2	12	0	143	67	81	0	64	3	92	0	NI	9
D. NON-ENGLISH SPEAKING NON-HEAD START CHILDREN PARTICIPATING IN PROGRAM	12=Yes 13=No	NO	NO	YES	YES	YES	NO	NO	NO	YES	NO	YES	NO	NO
E. OUTREACH METHODS (NON-HEAD START CHILDREN) 1. Mass Media	6=X 2=E	X			E	X					X			NO
2. Literature	9=X 1=E	X		X		X	X				X			
Community Organizations 3. Public	7=X 1=E	X			X			X						
4. Voluntary	5=X	X			X			X						
5. Parent Involvement Component	12=P 1=PE 7=X	P	P	P/E	P	X		P		P	X	P	P	P
6. Door-to-Door Contacts	9=P 3=X					P	P	X			P			
7. Telephone	5=X 2=E	X		E	X	E								
8. Letters	11=X 1=E	X		X	X	X	X				X			
9. Other	7=X 1=P				X		X							
F. CHANGES INITIATED IN OUTREACH METHODS SINCE HS/FIRST START-UP	16=No 9=Yes	NO	NO	NO	NO	NO	YES	NO	NO	NO	NO	YES	NO	YES
G. EFFECTIVENESS OF OUTREACH METHODS:														
Cumulative Certification Minus Prior Certification 1. Head Start	1614	151	34	0	0	110	16	1,069	6	-0	176	0	NI	NI
2. Non-Head Start	3159	58	267	40	45	35	56	500	30	404	63	0	NI	NI

Code: X- Outreach Method Used
E- English Speaking, Outreach Method Only
P- Most Effective Outreach Method Used
NI-No Information

OUTREACH BY SELECTED PROJECTS

TABLE IX-B	TEXAS (VI)			MISSOURI (VII)		MONTANA (VIII)			CALIFORNIA (IX)		OREGON (X)			
	Lubbock	Amarillo	Laredo (IMPD)	Appleton	Springfield	Billings	Blackfeet (IMPD)	Fort Peck (IMPD)	El Centro	Fresno (IMPD)	Eugene	Medford		
A. CHILDREN PARTICIPATING (CUMULATIVE): 1. Total	115	941	NI	252	621	167	624	344	NI	NI	229	1802		
2. Head Start	112	896	NI	235	515	147	174	344	NI	NI	128	152		
3. Non-Head Start	3	45	NI	17	106	20	450	0	NI	NI	101	1650		
B. SIBLINGS AMONG NON-HEAD START CHILDREN: 1. Number	1	41	146	NI	2	7	NI*	0	49	47	100	28		
2. Per cent	50	91	100	NI	100	23	NI*	0	98	57	99	62		
C. NO. OF NON-HEAD START CHILDREN CERTIFIED PRIOR TO PROGRAM	1	38	6	NI	5	17	0	0	19	25	97	31		
D. NON-ENGLISH SPEAKING NON-HEAD START CHILDREN PARTICIPATING IN PROGRAM	YES	YES	YES	NO	NO	YES	NO	NO	YES	YES	NO	YES		
E. OUTREACH METHODS (NON-HEAD START CHILDREN) 1. Mass Media									E	X	X	X		
2. Literature						X		X		X	X	E		
Community Organizations 3. Public								X	X	X	X	E		
4. Voluntary										X	X			
5. Parent Involvement Component	P		X		P	P	X		P	X	X	X		
6. Door-to-Door Contacts			P	X	X		P	P		P	P	P		
7. Telephone						X			X			X		
8. Letters					X	X	X		X		X	E		
9. Other				P			X	X	X	X	X			
F. CHANGES INITIATED IN OUTREACH METHODS SINCE HS/EPSDT START-UP	NO	NO	NO	NO	NO	YES	YES	YES	NO	YES	YES	YES		
G. EFFECTIVENESS OF OUT-REACH METHODS:	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨	▨
Cumulative Certification Minus Prior Certification 1. Head Start	0	7	NI	NI	1	0	24	0	NI	NI	13	7		
2. Non-Head Start	0	7	NI	NI	101	0	30	0	NI	NI	4	1,519		

Code: X- Outreach Method Used
E- English Speaking Outreach Method Only
P- Most Effective Outreach Method Used
[illegible]

B. ANALYSIS OF FINDINGS ON OPERATION OF OUTREACH

Outreach to non-Head Start children was concentrated on siblings of Head Start enrollees. There were 19 selected projects which reported participation by non-Head Start children on intake forms. Four projects indicated that siblings accounted for 100% of the non-Head Start population. In six other projects, siblings accounted for between 91 and 99% of non-Head Start children reached. Three projects--Leominster, Worcester and Baltimore--exhibited an opposite pattern: siblings only accounted for 6%, 0% and 5% of their non-Head Start EPSDT population. Participation by siblings ranged from 23% to 67% in the six other projects.

Two of the selected projects did not report reaching any non-Head Start children. At Fort Peck, this situation resulted from the refusal of the local welfare office to provide a list of Medicaid siblings, and their active discouragement of Head Start outreach to non-Head Start children. The Danville project did not feel they had the time or resources to serve non-Head Start children.

Also, there was confusion in some Head Start projects as to the requirement to serve non-Head Start children. The intake data did not reflect any participation by non-Head Start children, including siblings, in the Toms River project, for instance. This project did serve a small number of this population, but the percentage could not be calculated from available information. A similar situation existed for the Blackfeet Tribe.

The success of the selected projects in reaching non-Head Start children who had been previously certified for Medicaid varied greatly across projects. Of the total number of non-Head Start children reached by the selected projects in the collaborative effort, 711, or 19% of the total, had been previously certified. (For purposes of this analysis, the discussion is based upon the twenty-five selected projects presented in Table IX-B).

The largest number of previously certified non-Head Start children reached was 143 in Paterson; in contrast, the least number of non-Head Start children in the category was 0 in the Blackfeet Tribe.

The variation by percentage of non-Head Start children who were medicaid certified to the total non-Head Start children participating in the collaborative effort is, however, more noteworthy. The projects reaching the highest percentage of such children were Lubbock and Billings with only 100%; but Lubbock only involved one child. Cook County and Medford reached the lowest percentages of previously certified children, 1% and 2% respectively. The median for the seventeen selected projects for which percentages could be calculated was 59%.

In reviewing this data, it appears that those projects which reported large percentages of Medicaid eligible children actually recruited non-Head Start children whom they know to be eligible. On the other hand, those projects with low percentages undoubtedly recruited in the general community.

Twelve projects reached non-English speaking children. The other thirteen were located in predominantly English speaking areas. It was interesting that all of the projects in Region I reached such children as did those in Region VI and IX, the latter being located in Texas and California, respectively.

Of the nine different outreach methods used (reference pages IV-36 and IV-37) by selected projects, use of the Parent Involvement Component was the most frequently used method (21 of 23 projects) and was perceived to be the most effective method by thirteen projects. This method was the only form of outreach for non-Head Start children used by six projects. Through the Parent Involvement Component, Head Start projects were able to bring to bear existing program resources in the implementation of the EPSDT effort. Undoubtedly, they were able to disseminate information through the Parent Policy Council and some actively engaged parents themselves to augment the outreach activity. Parent involvement staff, through their daily activities, were able to encourage parents to enroll the siblings of Head Start children into the EPSDT program.

The second most frequently used method for outreach was door-to-door contact (12 of 23 selected projects) and was perceived to be most effective by 75% of the selected projects using this method. Other methods such as mass media, literature, community organizations, etc. tended to be used less frequently. Two projects reported that they did not provide for any outreach to non-Head Start children.

All projects seeking to recruit non-English speaking non-Head Start children used bilingual outreach methods. Bilingual approaches were used by at least two projects for every type of outreach. In addition, eight projects reported that they used at least one bilingual outreach method and the overall perception of effectiveness of these methods are similar, on a proportionate basis, as described for non-bilingual methods. Mass media, community organizations and the telephone were the less frequently used method for bilingual outreach.

An analysis of the effectiveness of outreach as measured by the differences between cumulative and prior certification for non-Head Start children reported on End of Year Status forms indicates that the projects were successful in reaching non-Head Start children. Effectiveness, in this instance, is measured by the ability of the Head Start projects to recruit potentially Medicaid eligible non-Head Start children and certify them throughout the year. All non-Head Start children who had not been certified previously attained Medicaid certification sometime during the program year. Part of this apparent success may be attributed to the recording of the cumulative data on the End of Year Status report. A comparison of this data to the percentage of certified/eligible children presented in Table III-A indicates that the selected projects tended to focus on the Medicaid eligible and therefore certifiable non-Head Start child. This pattern indicates the projects' awareness of the responsiveness to the objective of reaching children potentially eligible for EPSDT services so that they can be certified and actually receive these services.

The selected projects were less successful in reaching Head Start children who could be Medicaid certified during the course of the year. The percentage of such children reached among all selected projects was 29%. There was also considerable inter-project variations in this case, with reported low incidences of children reached in Springfield and Eugene, 1% and 2%, respectively and a reported high frequency of 100% in Cleveland. The median for all projects was 12%. This pattern among Head Start children may reflect the discrepancy between eligibility standards for Medicaid and Head Start services.

All projects were asked to report the numbers of children certified as a result of their outreach efforts. In the case of the selected projects, the number of Head Start children whom the projects assisted in receiving certification was generally low.

Exhibit V provides data on the number and percentage of Head Start and non-Head Start children certified during the demonstration year. The data indicates considerable variations among the projects. Apparently greater effort was extended on certification of Head Start children as compared to non-Head Start children. Certification of Head Start under the Collaborative Effort ranges from a high of 83% to a low of 0, with an average of 31%. In the case of non-Head Start children, the range was from 30% to 0%, with an average of 6%.

Admittedly, this data does not reflect those attempts at certification which were average but still unsuccessful. In many locations certification was hampered by bureaucratic processes and delays. Moreover, other data (Section III) indicates that a substantial percentage of eligible children, particularly non-Head Start children, were certified during the demonstration year. Nevertheless, the data suggest that Head Start efforts at securing certification for EPSDT participants were limited in the results obtained.

EXHIBIT V

HEAD START SUPPORT OF CERTIFICATION FOR EPSDT PARTICIPANTS

Selected Projects	Head Start		Non-Head Start	
	No.	%*	No.	%*
Leominster, Massachusetts	30	20%	12	21%
Worcester, Massachusetts	10	29	0	0
Toms River, New Jersey	5	NC	2	5
Paterson, New Jersey	0	0	0	0
Trenton, New Jersey	8	9	4	11
Baltimore, Maryland	5	31	0	0
Cleveland, Mississippi	197	18	111	22
Kingston, Tennessee	3	50	9	30
Cook County, Illinois	39	NC	1	0
East St. Louis, Illinois	0	0	0	0
Danville, Illinois	0	0	0	0
Cincinnati, Ohio	NI	NI	NI	NI
Dayton, Ohio	NI	NI	NI	NI
Lubbock, Texas	6	NC	1	NC
Amarillo, Texas	27	NC	15	NC
Laredo, Texas	NI	NI	NI	NI
Appleton, Missouri	NI	NI	NI	NI
Springfield, Missouri	0	0	0	0
Billings, Montana	0	0	0	0
Blackfeet Tribe, Montana	36	NC	0	0
Fort Peck, Montana	30	83	0	0
El Centro, California	NI	NI	NI	NI
Fresno, California	NI	NI	NI	NI
Eugene, Oregon	1	8	0	0
Medford, Oregon	NI	NI	NI	NI

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* Percentages calculated on number of children reportedly certified during demonstration year. NG= not calculated; data was inconsistent.

C. CONCLUSIONS ON OPERATION OF OUTREACH

1. The Head Start Parent Involvement Component was found to be the most effective outreach method by the Head Start projects for recruiting non-Head Start children. Through the use of parent involvement, the projects were able to utilize existing program resources. Many projects perceived door-to-door contact also as effective in reaching non-Head Start children.

2. The projects were highly successful in obtaining Medicaid certification for non-Head Start children who had not been certified prior to entry into the collaboration. They were relatively less successful with the Head Start population, reflecting possible discrepancies between the eligibility standards for Medicaid and Head Start.

D. RECOMMENDATIONS ON OPERATION OF OUTREACH

1. Because of the demonstrated success of the Parent Involvement Component in providing for outreach, Head Start programs should be encouraged to fully utilize this resource in order to insure that all siblings of Head Start enrollees become participants in the EPSDT effort. Parent involvement staff as well as the Parent Policy Council should be provided specific training in this regard.

2. Door-to-door contact as a specific outreach method for EPSDT should be fully exploited, particularly during the period when the Head Start staff is recruiting children for enrollment in the Head Start program.

3. OCD should review with SRS the feasibility of providing Medicaid certification to low income preschool children on the basis of their enrollment in the Head Start program. Because the income eligibility differences (in dollars) tend to be minimal between Medicaid and Head Start, the designation of Head Start enrollment as a specific eligibility standard for Medicaid/EPSDT would facilitate the certification of a particular group of low-income pre-school children for comprehensive health services.

A. OPERATION OF FOLLOW-UP (Table IX-C)

Both the SRS guidelines for EPSDT and the OCD guidelines for the collaborative effort reflect the importance of two components of a successful program. These two components are:

- Tracking, i.e., identifying services received against requirements with both screening and treatment by child.
- Verification, i.e., insuring that services required by each child are received.

Provisions made by the selected projects for tracking and verification are described in Table IX-C. The table does not include data on required and completed follow-up as this data is not currently available. The table does, however, contain data on the agencies responsible for the tracking of Head Start and non-Head Start children, as well as data on the adequacy of tracking. The agencies are categorized as; The Head Start program (Head Start); public agencies (PA): voluntary agency (VA); no responsible agency (N=None); not applicable (NA) indicates that there was no real service of non-Head Start children, or that, at best, a limited number of non-Head Start children were reached, and/or, that no constant contact was maintained.

TABLE IX-C

FOLLOW-UP BY SELECTED PROJECTS

SELECTED PROJECTS BY STATE	A			B			C				D								
	CHILDREN PARTICIPATING (CUMULATIVE)			UNITS OF FOLLOW-UP REQUIRED /Completed			TRACKING				VERIFICATION								
							Responsible Agency		Adequacy		Record of Services Received		Responsible Agency		Existence of Controls Over Non-Head Start Providers of Services				Adecua
															Screening		Treatment		
	1 TOTAL	2 HEAD START	3 NON-HEAD START	1 TOTAL	2 HEAD START	3 NON-HEAD START	1 HS	2 NHS	3 HS	4 NHS	1 HS	2 NHS	3 HS	4 NHS	5 HS	6 NHS	7 HS	8 NHS	9 HS
TOTALS FOR SELECTED PROJECTS	13,259	8,870	4,389																
MASSACHUSETTS (I): Leominster	335	264	71				HS	HS	G	G	Yes	Yes	HS	HS	Yes	Yes	Yes	Yes	G
Worcester	743	464	279				HS	NA	G	NA	Yes	NA	HS	NA	Yes	NA	Yes	NA	G
NEW JERSEY (II): Toms River	169	129	40	To be completed			HS	HS	G	A	Yes	Yes	HS	HS	Yes	Yes	Yes	Yes	G
Paterson	400	190	210	for final report			HS	HS	E	E	Yes	Yes	HS	HS	Yes	Yes	Yes	Yes	E
Trenton	384	282	102				HS	HS	G	G	Yes	Yes	HS	HS	Yes	Yes	Yes	Yes	G
MARYLAND (III): Baltimore	625	488	137				HS	PA	G	P	Yes	Yes	HS	PA	Yes	Yes	Yes	Yes	G
MISSISSIPPI (IV): Cleveland	3,444	2,944	500				HS	HS	G	A	Yes	No	HS	PA	Yes	Yes	Yes	No	G
TENNESSEE (IV): Kingston	261	167	94				HS	HS+PA	G	G	Yes	No	HS	HS+PA	Yes	Yes	Yes	Yes	G
ILLINOIS (V): Cook County	906	499	407				HS	HS	G	G	Yes	Yes	HS	HS	Yes	Yes	Yes	Yes	G
East St. Louis	613	458	155				HS	HS	A	A	Yes	Yes	HS	HS	Yes	Yes	Yes	Yes	G
Danville	282	282	0				HS	NA	G	NA	Yes	NA	HS	NA	Yes	NA	Yes	NA	G
OHIO (V): Cincinnati	NI	NI	NI				HS	HS	G	A	Yes	Yes	HS	HS	Yes	Yes	Yes	Yes	G

CODE:

HS = Head Start
PA = Public Agency
VA = Voluntary Agency
N = None
NI = No Information

NA = Not Applicable
E = Excellent
G = Good
A = Adequate
P = Poor

TABLE IX-C

FOLLOW-UP BY SELECTED PROJECTS

SELECTED PROJECTS BY STATE	A			B			C				D								
	CHILDREN PARTICIPATING (CUMULATIVE)			UNITS OF FOLLOW-UP REQUIRED			TRACKING				VERIFICATION								
							Responsible Agency		Adequacy		Record of Services Received		Responsible Agency		Existence of Controls Over Non-Head Start Providers of Services				Adecua
															Screening		Treatment		
	1	2	3	1	2	3	1	2	3	4	1	2	3	4	5	6	7	8	9
	TOTAL	HEAD START	NON-HEAD START	TOTAL	HEAD START	NON-HEAD START	HS	NHS	HS	NHS	HS	NHS	HS	NHS	HS	NHS	HS	NHS	HS
OHIO (Cont'd.) Dayton	NI	NI	NI				HS	HS	A	P	Yes	No	HS	HS	Yes	Yes	Yes	Yes	A
TEXAS (VI): Lubbock	115	112	3				HS+ PA	HS+ PA	A	NI	Yes	NI	HS	NI	Yes	NI	Yes	NI	A
Amarillo	941	896	45				HS	NA	G	NA	Yes	NA	HS	NA	Yes	NA	Yes	NA	A
Laredo (IMPD)	NI	NI	NI				HS	HS	G	G	Yes	Yes	HS	HS	Yes	Yes	Yes	Yes	G
MISSOURI (VII): Appleton	252	235	17				HS	NA	G	NA	Yes	NA	HS	PA	Yes	NA	Yes	NA	G
Springfield	621	515	106				HS	NA	A	NA	Yes	NA	HS	NA	Yes	NA	Yes	NA	G
MONTANA (VIII): Billings	167	147	20				HS+ PA	PA	G	P	Yes	Yes	HS+ PA	PA	Yes	Yes	Yes	Yes	G
Blackfeet (IMPD)	624	174	450				HS+ PA	HS+ PA	A	P	Yes	Yes	HS+ PA	PA	Yes	Yes	Yes	Yes	A
Fort Peck (IMPD)	344	344	0				HS+ PA	PA	G	P	Yes	Yes	HS+ PA	PA	Yes	Yes	Yes	Yes	G
CALIFORNIA (IX): El Centro	NI	NI	NI				HS	HS	G	G	Yes	Yes	HS	HS	Yes	Yes	Yes	Yes	G
Fresno (IMPD)	NI	NI	NI				HS	HS	G	G	Yes	Yes	HS	HS	Yes	Yes	Yes	Yes	G
OREGON (X): Eugene	229	128	101				HS+ PA	HS+ PA	G	A	Yes	Yes	HS+ PA	HS+ PA	Yes	Yes	Yes	Yes	G
Medford	1,802	152	1,650				HS	PA	G	P	Yes	Yes	HS+ PA	PA	Yes	Yes	Yes	No	G

CODE:

HS = Head Start
PA = Public Agency
VA = Voluntary Agency
N = None
NI = No Information

NA = Not Applicable
E = Excellent
G = Good
A = Adequate
P = Poor

Based on observations of recordkeeping systems and information obtained through interviews during the site visits, adequacy was categorized as: excellent (E), good (G), adequate (A), poor (P), not applicable (NA--as above), and no information (NI).

B. ANALYSIS OF FINDINGS ON OPERATION OF FOLLOW-UP

Table IX-C indicates differences between the tracking services provided for Head Start and non-Head Start populations. Head Start is the responsible agency for tracking Head Start children in 20 of the 25 selected projects. In the other five projects, the Head Start program is responsible for activities in conjunction with a public agency.

Also, the adequacy of tracking for Head Start children was found to be good or excellent in 80% of the projects and adequate in the remaining 20%. In those instances where the public agency cooperated in providing tracking services, the projects tended to rate this service good for Head Start children and adequate or poor for non-Head Start children.

In the case of non-Head Start children generally, tracking was found to be good or excellent in 40% of the projects where it was provided, adequate in about 25%, and poor in 35% of the projects. Although Head Start was also the dominant responsible agency in these instances, its role was less frequent (14 out of

21) as compared to the tracking provided to Head Start children. There was more frequent involvement of public agencies in providing tracking services for non-Head Start children compared to the Head Start group. Four projects indicated the public agency as the sole responsible agency for tracking and three others stated that the public agency provided this service in conjunction with the Head Start program.

For verification of services received, the responsible agency and adequacy are identified. Data is presented also on records of services received and on control over non-Head Start providers of services. The existence of controls is differentiated by screening and treatment for both Head Start and non-Head Start children.

Head Start was the sole responsible agency for verification for Head Start children in 80% of the selected projects and shared this responsibility with a public agency in the remaining projects. The public agency was the responsible provider of verification for non-Head Start children for seven projects and shared responsibility with selected Head Start projects in three instances.

Head Start remains the dominant responsible agency for verification in 11 of 21 projects. The adequacy of verification is also similar to the pattern for tracking with the services provided to Head Start children again rated higher, i.e., 84% of the projects provided good or excellent verification for Head Start children and 16% were adequate, as compared to 42% of the projects providing good or excellent verification for non-Head Start children, and 21% providing adequate services and 37% of them described as poor.

The finding that better verification was provided for Head Start children than for non-Head Start children also holds with respect to whether records of services were received by the responsible agencies or control exercised over the providers of screening and treatment services. All selected Head Start projects reportedly obtained a record of services received, and also exercised controls over other service providers in the case of Head Start children. Records of services received by non-Head Start children were not obtained in three projects and controls were not exercised over treatment in two projects where some activities were known to have occurred. For both record of services received and existence of controls, there was a substantial number of occurances of "Not Applicable" or "No Information"; for instance, in Danville, Worcester, Amarillo, Appleton, and Springfield, probably indicating that minimal, if any, controls were exercised over non-Head Start children.

A comparison of the number of children participating in each project--Head Start and non-Head Start--with the various follow-up services seems to indicate that program size bore no relationship to the adequacy of tracking and verification services provided.

C. CONCLUSIONS ON OPERATION OF FOLLOW-UP

1. All Head Start children involved in the EPSDT Collaborative Effort received follow-up services, both tracking and verification. The Head Start project was usually the responsible agency for the provision of these services, and most projects deemed them adequate or better. The non-Head Start child was less likely to receive follow-up services, particularly verification.

2. The relatively low incidence of public agencies providing tracking and verification services suggests the lack of a systematic approach by state Medicaid/EPSDT agencies to the delivery of EPSDT in accordance with the federal regulations.

A. OPERATION OF RECORDKEEPING (TABLE IX-D)

OCD guidelines specify that individual records are to be maintained for all children participating in the EPSDT/ collaborative effort. The Health Services bookkeeping system is suggested as a possibility by OCD with recognition of acceptability of alternatives. Recordkeeping provisions made by the selected projects are described in terms of three categories in Table IX-D:

- continuity of contact, which identifies whether these selected projects retain records for Head Start and non-Head Start children at the end of the program year, and also to whom records were transferred in the case of Head Start children.
- impact of the EPSDT effort on recordkeeping, which identifies whether the collaborative effort stimulated greater use of pre-existing forms or development of new ones.
- quality of recordkeeping as reflected in the condition of records maintained by the projects.

As in other tables in this section, "Not Applicable" indicates that a limited number of non-Head Start children were recruited and/or no contact was maintained with them. With respect to continuity of contact, program retention of records in the case of Head Start children did not preclude the transfer to another party with subsequent responsibility for the child's health services. Such parties include the school(s), parent, (Pa), and/or provider (Pr).

TABLE IX-D

CONTINUITY OF CONTACT AND RECORDKEEPING: BY SELECTED PROJECTS

SELECTED PROJECTS BY STATE	A			B			C	
	CONTINUITY OF CONTACT			EPSDT IMPACT ON RECORDKEEPING			QUALITY OF RECORDKEEPING	
	Records Retained By Program		3 Records of Head Start Children Transferred With Child	1 Increased Use of Pre-Existing Record Forms HS ONLY	Development of New Forms		Condition of Records Maintained By Program	
	1 Head Start	2 Non-Head Start			2 Head Start	3 Non-Head Start	1 Head Start	2 Non-Head Start
MASSACHUSETTS (I): Leominster	No	Yes	S	No	No	No	G	A
Worcester	No	No	S	No	Yes	NA	G	NA
NEW JERSEY (II): Toms River	NI	NI	NI	No	No	No	G	NI*
Paterson	No	Yes	Pa, S	No	Yes	Yes	G	G
Trenton	Yes	Yes	Pa, S	No	No	No	G	NA
MARYLAND (III): Baltimore	Yes	Yes	Pa, S	No	No	NA	G	NA
MISSISSIPPI (IV): Cleveland	Yes	Yes	NI	Yes	Yes	No	G	P
TENNESSEE (IV): Kingston	Yes	No	S, Pa	No	No	NI	A	P
ILLINOIS (V): Cook County	Yes	Yes	S, P, Pa	NI	NI	NI	G	G
East St. Louis	No	Yes	S	No	Yes	Yes	P	P
Danville	Yes	NA	S	Yes	NI	NA	G	NA
OHIO (V): Cincinnati	NI	NI	NI	No	No	No	G	G
Dayton	NI	NI	NI	No	No	Yes	A	P

CODE:

S = School System	E = Excellent
Pa = Parent	G = Good
Pr = Provider	A = Adequate
NI = No Information	P = Poor
NA = Not Applicable	* Not processed because of late return

TABLE IX-D
(Cont'd.)

CONTINUITY OF CONTACT AND RECORDKEEPING: BY SELECTED PROJECTS

SELECTED PROJECTS BY STATE	A			B			C	
	CONTINUITY OF CONTACT			EPSDT IMPACT ON RECORDKEEPING			QUALITY OF RECORDKEEPING	
	Records Retained By Program		3 Records of Head Start Children Transferred With Child	1 Increased Use of Pre-Existing Record Forms HS ONLY	Development of New Forms		Condition of Records Maintained By Program	
	1 Head Start	2 Non-Head Start			2 Head Start	3 Non-Head Start	1 Head Start	2 Non-Head Start
TEXAS (VI): Lubbock	Yes	NA	Pa	No	No	NA	A	NA
Amarillo	Yes	No	S	NI	NI	NA	G	NA
Laredo (IMPD)	NI	NI	NI	No	No	No	G	A
MISSOURI (VII): Appleton	Yes	No	S, Pa	No	No	No	A	P
Springfield	Yes	Yes	NI	No	Yes	Yes	G	A
MONTANA (VIII): Billings	Yes	Yes	S	No	No	No	G	P
Blackfeet (IMPD)	Yes	No	Pa	No	No	No	A	P
Fort Peck (IMPD)	No	No	S	No	No	NA	A	NA
CALIFORNIA (IX): El Centro	NI	NI	NI	No	No	No	G	G
Fresno (IMPD)	NI	NI	NI	No	No	No	G	G
OREGON (X): Eugene	Yes	Yes	NI	No	Yes	No	G	A
Medford	Yes	No	S, Pa	No	No	No	G	P

CODE:

S = School System
Pa = Parent
Pr = Provider
NI = No Information
NA = Not Applicable

E = Excellent
G = Good
A = Adequate
P = Poor

B. ANALYSIS OF FINDINGS ON OPERATION OF RECORDKEEPING

Table IX-D shows that 75% of the selected projects on which information has been reported retained health records for their Head Start children, whereas only 52% retained such records for non-Head Start children involved in the collaborative effort. Where the project transferred records, the recipients were schools (seven times); combination of school and parents (six times); parents only (two times); and combination of school, parents, and provider (one time). It should be noted that a provider was never a sole recipient of the child's health records. Of the 9 projects retaining and transferring records on which information was available, 56% or five projects, transferred them to the combination of school and parents; 33% or three projects, transferred them to the child's school; and one to all possible recipients.

The impact of the EPSDT collaborative effort on Head Start health services recordkeeping was minimal, according to the data presented in Column B. This analysis explicitly excludes the evaluation forms which many projects reported, in the course of the site visits, were most useful. Reaction on the part of the projects is significant given the fact that many had been initially resistant to the evaluation study.

Only two of the 23 selected projects on which data was available, or about 10%, increased their use of record forms which had been used previously for Head Start children. Cleveland, Mississippi provided additional training for the center personnel responsible for recordkeeping and strengthening supervision of their efforts; Danville, Illinois emphasized more detailed and comprehensive completion of their existing forms.

Only six of the projects on which information was available--27%--developed new, individualized forms for Head Start children due to the collaborative effort. A lower percentage--25%--developed such forms for non-Head Start children. Projects did, however, use various types of aggregate reports or records according to site visit data. Many of these reports were copies of those supplied by the responsible local agency with all the inadequancies or variations thereof.

The contrast between the quality of project records maintained for Head Start and non-Head Start children is striking. For Head Start children, records were observed to be of good quality in 73%, or 18 of the selected projects; adequate in 24%, or 6 of the projects; and poor in only 4%, or 1 project. Conversely, records for non-Head Start children were observed to be good in only 5 projects, or 29%, or the 17 projects maintaining such records and adequate in 4 or 24%; they were poor in 8 projects or 47%. One project, Toms River, had not really begun operation of its recordkeeping system for non-Head Start children.

Supportive services were provided for non-Head Start children (7 of 8 possible services) in most of the projects (21 of 25) and Head Start played a major role as the direct provider of such services.

The most frequently provided services, in descending order of frequency, were:

- tracking and verification of health service receipt provided
- publicity and certification provided in 20 of 25 cases
- identification and recruitment as well as transportation provided in 19 of 25 cases.

The frequency with which Head Start served as the direct and sole provider was as follows:

- publicity provided by Head Start only in 16 of 25 projects
- transportation and tracking solely provided by Head Start in 14 projects and record-keeping in 13 of 25.
- certification provided in 12 projects and identification in 11 projects.

C. CONCLUSIONS ON OPERATION OF RECORDKEEPING

Recordkeeping for non-Head Start children was considerably weaker than that for Head Start children. This condition is typical of the status of other supportive services for non-Head Start children as previsously discussed. This pattern may reflect lack of resources, a factor noted in the site visits. No selected project, however, appears to have attempted to secure reimbursement for such services. Of equal interest is the minimal impact of the collaborative effort on Head Start projects' recordkeeping.

D. RECOMMENDATIONS

OCD should seriously consider requiring that records be kept on the provision of services to non-Head Start children comparable to the information now maintained on Head Start children to assure adequate documentation of medical care and follow-up as well as provide a basis for further study and comparative analysis between the two groups of children.

V. HEAD START/EPSDT RELATIONS WITH LOCAL, STATE, AND FEDERAL AGENCIES

Introduction

This section presents analyses of the relationships between the selected projects and local, state and federal agencies within the context of the EPSDT institutional framework. This framework consists of the formal EPSDT state plans and their operation through contracts and other mechanisms for delegating responsibility among welfare, health, etc. agencies at the state and local levels. In addition, the analysis indicates the manner in which these provisions affected the actions and attitudes of providers, with consequent effects on the collaborative effort.

This section presents the following tables:

Table X - State EPSDT Plan Profile for Target States

Table XI - State Medicaid Plan Profile for Target States

Table XII - State/Local EPSDT/Organizational Responsibility Profile for Target States

Table XIII - Provider Provisions and Attitudes by Selected Projects

Table XIV - Head Start/EPSDT Selected Project Agreements and Relations with State and Local Medicaid Agencies

Table XV - Types and Adequacy of Technical Assistance by Source for Selected Projects.

An additional table, Comparison of State Medicaid Services and Head Start Performance Standards for Target States and Selected Projects (X-A), will be included in the final report. This table is not included here due to the frequency of omissions caused by the difficulties in obtaining required details of state Medicaid plans. This difficulty also accounts for the tentative nature of some of the subsequent analyses, as noted in the discussion.

A. STATE EPSDT PLAN FOR TARGET STATES (TABLE X)

As previously mentioned, all states have been required to provide EPSDT services since February 1972. In support of this requirement, they have been encouraged to develop a statewide coordinated and integrated evaluation process and health care system for this program. The Social and Rehabilitative Services (SRS), DHEW issued formal regulations in November 1971 setting forth the requirements for state implementation of the Medicaid/EPSDT program. The Federal regulations do not require presentation of a formal EPSDT plan by a state for approval prior to implementation. It is expected that the EPSDT program will be a further refinement of the state's Medicaid (Title XIX) plan with specific focus on preventive health services and early detection and treatment of eligible children under age 21.

SRS does, however, mandate certain basic provisions for a state EPSDT program and recommends minimum levels of services. The states are required to utilize and/or develop community resources to provide screening and diagnostic services. The federal reporting requirements for EPSDT are designed to insure that a state has developed the appropriate administrative mechanisms to inform eligible families, provide or arrange for screening services and provide or arrange for corrective treatment. Copies of the formal EPSDT plans for each of the collaborative effort target states were obtained so that analyses of their provisions and their compliance with federal standards could be made.

B. ANALYSIS OF FINDINGS: STATE EPSDT PLAN FOR TARGET STATES

Eleven out of the 12 target states in the collaborative effort had prepared a state plan for EPSDT as of June, 1975; and 8 of them had distributed the plan, as shown in Table X. Three had developed a plan but no distribution of the document had been made; and one state, Montana, had no specific EPSDT plan although some services are being provided.

The contents of the various plans were analyzed to determine whether the states had defined and provided for specific services, e.g., screening, diagnosis, outreach, transportation, recordkeeping, etc. Only one state, Ohio, provided definitions for all seven service categories. On the other hand, Maryland defined only one category of service*, and New Jersey and Missouri provided definitions for only periodic and screening.

The categories most usually defined were periodic and screening, as reflected in nine out of 12 state plans. Only three out of 12 states defined outreach.

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* Only minimal information was available on the specifics of Maryland's written plan at the time of preparation of this report.

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TABLE X STATE EPSDT PLAN PROFILE FOR TARGET STATES

TARGET STATES (BY REGION)	A			B							C		D		E		F	G		
	EPSDT PLAN			DEFINITIONS PROVIDED							OUTREACH		PUBLICITY		TRANSPORTATION		COMPARABILITY BETWEEN STATE AND FEDERAL SCREENING PROCEDURES	FOLLOW-UP RECORDKEEPING		
	1	2	3	1	2	3	4	5	6	7	1	2	1	2	1	2		1	2	3
	Distributed	Developed	None	Early	Periodic	Screening	Diagnosis	Treatment	Outreach	Supportive Services	Provirions	Operational Responsibility	Provisions	Operational Responsibility	Provisions	Operational Responsibility		Provisions	Operational Responsibility	Type
MASSACHUSETTS (I)	X			X	X	X	N	N	N	N	X	OG	X	I	X	I	different	X	I	C
NEW JERSEY (II)	X			N	X	X	N	N	N	N	X	OG	X	J	X	J	same	X	I	C
MARYLAND (III)	X			NI	NI	NI	NI	NI	NI	X	X	OG	X	I	X	OG	NI	X	OG	NI
MISSISSIPPI (IV)		X		X	N	X	X	X	X	X	X	OG	X	J	X	OG	different	X	J	C
TENNESSEE (IV)	X			X	X	X	N	N	N	X	X	OG	N	NA	N	NA	same	X	OG	M
ILLINOIS (V)	X			N	X	N	N	N	N	N	N	NA	N	NA	N	NA	same	X	I	C
OHIO (V)	X			X	X	X	X	X	X	X	X	OG	X	OG	X	OG	same	X	I	C
TEXAS (VI)	X			X	X	X	X	X	N	N	X	I	N	N	X	I	different	X	I	C
MISSOURI (VII)		X		N	X	X	N	N	N	N	X	I	N	NA	X	OG	same	X	I	C
MONTANA (VIII)			X	N	N	N	N	N	N	N	N	NA	N	NA	N	NA	NI	N	NA	M
CALIFORNIA (IX)		X		X	X	X	X	X	X	N	X	OG	X	OG	N	NA	same	X	J	C
OREGON (X)	X			X	X	X	X	X	N	N	N	NA	N	NA	N	NA	different	X	OG	M
TOTALS	8	3	1	N=4 NI=1 X=7	N=2 NI=1 X=9	N=2 NI=1 X=9	N=6 NI=1 X=5	N=6 NI=1 X=3	N=8 NI=1 X=3	N=8 X=4	N=3 9=X	NA=3 OG=7	N=6 N=6	I=2 J=2 NA=5 OG=2	N=5 X=7	I=2 J=1 NA=5 OG=4	Diff=4 NI=2 Same =6	N=1 11=X	I=6 J=2 NA=1 OG=3	C=8 M=3 NI=1

CODE: OG= Other Governmental P= Private N= None NI= No Information M=Manual
I= Internal J= Joint C= Computer NA= Not Applicable

The plans were analyzed to determine whether specific provisions had been made for supportive services such as outreach, publicity and transportation. An attempt was made to ascertain whether the target states had developed screening procedures comparable to SRS standards or systems for follow-up recordkeeping. (These latter provisions are crucial if there is to be effective implementation of the EPSDT program.) A determination was then made of the administrative unit that was responsible for operating these services under the state plan.

For purposes of analysis, where state plans specified that the state public welfare agency had operational responsibility for the specific service, this designation was coded as I or internal. This category included central and decentralized or field units. Instances where the state public welfare agency shared the responsibility with another agency (public or private) were coded as J or joint; in the case where another governmental agency was delegated the responsibility, the code OG, or other governmental unit, was used.

Nine out of 12 state plans provided for outreach; seven provided for transportation services; and six for publicity. In the case of outreach services, seven out of the eight states delegated operational responsibility for outreach to a governmental agency other than the EPSDT unit while two retained this function.

For publicity, two state plans provided for sharing this function between the EPSDT unit and another governmental unit and two retained operational responsibility. There was variation in the manner in which operational responsibility for transportation services was designated in the state EPSDT plan. Five states delegated this responsibility to a governmental agency other than the EPSDT unit, and two retained the function.

Table X(F) shows that there was comparability between state screening procedures and those recommended by SRS in five state EPSDT plans. There were gaps or omissions of certain procedures in five other plans.

C. CONCLUSIONS: STATE EPSDT PLAN FOR TARGET STATES

1. Definitions of service by the states tended to provide for those functions which are particular to the EPSDT program, i.e. early, periodic, screening. Those functions which are more traditional or universally provided by health and social service systems such as diagnosis, treatment supportive services and outreach were generally not clearly defined by the states.

2. All states except Montana provided for follow-up recordkeeping. In the majority -- five of the states -- the EPSDT unit retained operational responsibility for this function. Four states delegated operational responsibility for follow-up recordkeeping to a governmental agency other than the EPSDT unit, and one state utilized the services of a private insurance company. Eight states had computerized recordkeeping systems and three, including Montana, maintained their data manually.

A. STATE MEDICAID/EPSDT PLAN PROFILE FOR TARGET STATES (TABLE XI)

The written EPSDT state plans did not, in many instances, encompass all aspects of the associated Medicaid plan and the provisions under which the state Title XIX agency actually operated specific EPSDT functions. Therefore, Boone, Young & Associates reviewed copies of the state Medicaid, or Title XIX, plans together with supporting documentation and followed up through telephone contact for information on administrative or functional areas that needed further clarification.

Table XI describes the extent to which the state public welfare agency retained the management of the EPSDT program in terms of four functions: administration, health services, support services, and fiscal. Administration includes such activities as establishment of overall policies, setting requirements for vendor status, eligibility determination, monitoring and evaluative activities, etc. Support services are defined as encompassing outreach, transportation, follow-up, recordkeeping, notification of eligible participants, and public information. Health and fiscal functions are self-explanatory.

B. ANALYSIS OF FINDINGS: STATE MEDICAID/EPSDT PLAN FOR FOR TARGET STATES

The table indicates that no state public welfare agency retained or totally delegated the management of all four functions under review. However, in Missouri and Oregon, the state welfare agency retained greater responsibility for three out

STATE MEDICAID PLAN PROFILE FOR TARGET STATES

TABLE XI	MASS. (I)	N.J. (II)	MD. (III)	MISS. (IV)	TENN. (IV)	ILL. (V)	OHIO (V)	TEXAS (VI)	MO. (VII)	MONT. (VIII)	CALIF. (IX)	ORE. (X)
A. STATE WELFARE AGENCY MANAGEMENT OF EPSDT:												
1. Administration	retained	partially delegated	partially delegated	partially delegated	partially delegated	partially delegated	partially delegated	partially delegated	retained	retained	totally delegated	retained
2. Health	partially delegated	totally delegated	totally delegated	totally delegated	totally delegated	partially delegated	totally delegated	totally delegated	retained	totally delegated	totally delegated	retained
3. Support	partially delegated	partially delegated	totally delegated	totally delegated	totally delegated	partially delegated	totally delegated	retained	partially delegated	partially delegated	totally delegated	partially delegated
4. Fiscal	partially delegated	totally delegated	partially retained	totally delegated	totally delegated	retained	retained	partially delegated	retained	retained	partially delegated	retained
B. PERSONS ELIGIBLE:												
1. Categorically Needy Only		X		X			X	X	X			X
2. Categorically and Medically Needy	X		X		X	X				X	X	
C. FREQUENCY OF ELIGIBILITY DETERMINATION			6 months	6 months		6 months		6 months	6 months			
D. ELIGIBLE VENDORS*	1,2,3,4,6	1,2,3,4,6	1,2,3,4,6	1,2,3,4,6	1,2,4,6	1,2,3,4,5,6	1,2,[illegible],4,5, 6	1,2,3,4,6	2,3,4,6	1,2,3,4,6	1,2,3,4,5, 6	1,2,3,4,5 6
E. SPECIFICITY OF EPSDT PLAN												
1. Detailed			X		X	X	X	X			X	X
2. General	X	X		X					X			
3. None										X		

*ELIGIBLE VENDOR CODE:

1. Public Health Agencies
2. Hospital
3. Private Voluntary Clinics
4. Private Physicians/Dentists
5. Community Agencies
6. Other health practioners

of four functions, and only partially delegated the management of supportive services. On the other hand, the state public welfare agency in Illinois partially delegated all functions except fiscal, while the Massachusetts agency retained administration but partially delegated all others. California, however, totally delegated all functions except fiscal, which it partially delegated to another agency. In summary, the health function was most frequently "totally delegated"--eight out of 12 state public welfare agencies reviewed, or 67% overall--compared to the other functions.

This pattern is to be expected since the management of the health function requires special expertise in health service delivery.

The function most frequently retained by the state public welfare agency, however, was fiscal management. In five out of 12 states,or 45% of those reviewed, this function was retained by the welfare agency.

Administration and support services were partially delegated to a greater extent than other functions, seven out of 12 state agencies, or 59%.

The diffusion of responsibility for managing various functions pertaining to EPSDT is not surprising given the history of the implementation of Title XIX among the states generally. There has been a marked tendency for health-related functions to be performed by public health rather than welfare agencies. However, many public welfare agencies have retained responsibility for fiscal management because of Title XIX requirements, but shared the operation of other administrative and support services. Because of the relatively low frequency with which the target state agencies retained the fiscal function, even though it was most often cited as being retained, it might be interesting to determine the extent to which this pattern correlates to the national trend.

This delegation of functions often underlies difficulties in coordination and poses problems to external entities such as Head Start which attempt to gain access to or influence the system. These results become clearer subsequently when operational realities of delegation are analyzed.

SRS permits the states to define eligibility for Medicaid in terms of either persons who are defined as categorically needy only (receiving financial assistance paid for in part by federal funds) or those who are categorically and medically needy(which may include persons with special needs for assistance regarding health services because of lower income or requirements for extensive health care). Analysis of the states' EPSDT plans indicated that six states--New Jersey, Mississippi, Ohio, Texas, Missouri, and Oregon--provided Medicaid, and therefore EPSDT services, only for those persons who are categorically needy. Massachusetts, Maryland, Tennessee, Illinois, Montana, and California, on the other hand, have more liberal eligibility criteria for Medicaid and include the medically needy. Information obtained in the on-site visits indicated that these differences have an important bearing.

It has been impossible, to date, to obtain complete information on the frequency with which states required redetermination of Medicaid eligibility. Redetermination is defined to mean personal interaction of the client with the responsible public agency including presentation of supporting documentation required to continue Medicaid eligibility as opposed to internal review of status, etc., by the agency. According to available information, five states, (Maryland, Mississippi, Illinois, Texas, and Missouri) specify that eligibility determination is to be done at 6-month intervals. Since information is not available on the other seven states, no analysis of this dimension is provided in this report.

SRS regulations are explicit in their directions that the state ESPDT agency use as many different types of providers as possible in the implementation of the EPSDT program. SRS also encourages efforts to provide vendor status for these various community providers and therefore reimbursement for services they render. The state Medicaid plans were reviewed to determine the types of providers deemed eligible for vendor status. The categories analyzed included public health agencies, hospitals, private voluntary clinics, private physicians/dentists, community agencies, and other health practitioners (optometrists, physical and rehabilitative therapists, etc.). Four target states, Illinois, Ohio, California, and Oregon, allowed for all six kinds of providers; six states excluded only community agencies as eligible vendors.

All of the target states deemed hospitals, private physicians/ dentists, and other health practitioners to be eligible vendors. The provisions for eligibility of other health practitioners varied extensively,with categories such as chiropractors and optometrists being frequently included. California, does, however, include a number of the more recently recognized health practitioners within its definitions of eligible vendors. All states except Missouri include public health agencies, and Tennessee was the only state to include private voluntary clinics.

In general, most, if not all, state EPSDT plans provided for traditional providers of medical and health services to be eligible vendors. There was much less frequency, only 50% of the states, of allowing community agencies to achieve similiar status. Such exclusion could potentially have an adverse effect upon the ability of the EPSDT agency to mount an effective information, outreach and screening program. Conversely, this situation may impede Head Start efforts to obtain reimbursement for services it can provide more effectively. One alternative not explicitly identified by the table is joint vendor status which is provided by Missouri. In this case, a community agency can be a vendor in concert with a more traditional provider. The Springfield project is scheduled to become a vendor under this provision in concert with a local, and supportive, physician.

The state plans were also reviewed to determine their level of specificity. It should again be noted that the plan in this regard includes additional information as provided in the state Title XIX plan or telephone contact. Seven out of the twelve state plans were found to be detailed; four provided only general information; and one had no plan to speak of. The level of detail correlated, however, with specific functions and subordinate activities and the extent to which responsibility was retained, with noteworthy exceptions. For example, supportive services tended to be least specific. Eligibility determination was also not generally detailed being an activity for which the public welfare agencies retained responsibility.

A. STATE/LOCAL EPSDT ORGANIZATIONAL RESPONSIBILITY IN TARGET STATES (TABLE XII)

Because of the gaps in information and lack of specificity about organizational responsibility and operational reality detected in the sources mentioned previously, additional information was collected during the site visits in an attempt to amplify these materials. Information was solicited from selected Head Start programs, public agencies, and community agencies including providers of service regarding their knowledge of and experiences with the ongoing operation of EPSDT. Their comments and insights helped broaden the picture of the organizational and operational aspects of the EPSDT system; in general, however, their knowledge was limited to their experiences. In addition, materials pertaining to EPSDT that had been distributed by state or local agencies were collected and reviewed. Since much information is still in the process of being gathered and submitted by state agencies in response to earlier inquiries, this analysis should be considered preliminary.

Organizational responsibility for EPSDT functions is described at two levels of administration in Table XII:

- interagency relationships at the state level
- state and local governmental agency relationships.

The data in this table represents a summary of the information from the various sources mentioned above. In instances where there is an inconsistency with the information presented in Table X or XI* greater weight was given to information and materials collected in the site visits. The most usual inconsistency is a function of the extent of actual delegation of responsibility by the state public welfare agency to another governmental unit as compared to the administrative mechanisms described in the state plan. It should be noted that in two instances, Mississippi and California, separate state agencies have been delegated almost complete authority for Medicaid/EPSDT. In Mississippi the responsibility was transferred to the Mississippi Medicaid Commission and in California new organizational entities--Child Health Disability Prevention Programs--are being established on the local level. Also of interest is New Jersey which has established interagency relationships among four different health and welfare units as well as a private insurance carrier. Information on five states is incomplete: Massachusetts, Maryland, Mississippi, Missouri, and Montana.

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* The state EPSDT plan for Massachusetts indicates that another governmental unit is responsible for outreach, but we found that the state public welfare agency also carried operational responsibility.

TABLE XII

STATE/LOCAL EPSDT ORGANIZATIONAL AND RESPONSIBILITY PROFILE FOR TARGET STATES

TARGET STATES	STATE LEVEL INTERAGENCY EPSDT RELATIONSHIPS										STATE AGENCY-LOCAL GOVERNMENT AGENCY RELATIONSHIPS									
			FUNCTIONS										FUNCTIONS							
	TYPE OF AGENCY	TYPE OF RELATIONSHIP	Medical	Outreach	Follow-up	Transportation	Recordkeeping	Eligibility Determination	Fiscal Management	Notification of Eligibles/Public Information	TYPE OF AGENCY	TYPE OF RELATIONSHIP	Medical	Outreach	Follow-up	Transportation	Recordkeeping	Eligibility Determination	Fiscal Management	Notification of Eligibles/Public Information
MASSACHUSETTS (I) (Information incomplete)	PW	NA	X	X						X										
	PH	I	X	X						X	LHB	I	X	X						
		C							X											
NEW JERSEY (II)	PW	NA					X				LWB	LA		X	X	X	X	X		X
	MA	IN	X								LHB	C	X							
	SHA	C	X								LMAU	SA	X							
	YFS	IN						X		X	YFS	I		X		X		X		
	PI	C							X											
MARYLAND (III) (Information incomplete)	PH	C	X	X					X	X	LHB	SA	X			X	X			X
											LWB	SA		X				X		X

PW=Public Welfare
PH=Public Health
YFS=Youth Family Services
SHA=State Health Agencies
MA=Dept. Medical Assistance
LWB=Local Welfare Board
LHB= Local Health Board
LMAU=Local Med. Asst. Unit
S=Structural Relationship
SA= State Administered
LA= Locally Administered
NA= Not Applicable
I=Informal Agreement
C=Contractual Agreement
PI=Private Insurance
CSD=Children's Services Division
CHDD=Child Health Disability Prevention Program

TABLE XII(cont.)

STATE/LOCAL EPSDT ORGANIZATIONAL AND RESPONSIBILITY PROFILE FOR TARGET STATES

TARGET STATES	STATE LEVEL INTERAGENCY EPSDT RELATIONSHIPS										STATE AGENCY-LOCAL GOVERNMENT AGENCY RELATIONSHIPS									
			FUNCTIONS										FUNCTIONS							
	TYPE OF AGENCY	TYPE OF RELATIONSHIP	Medical	Outreach	Follow-up	Transportation	Recordkeeping	Eligibility Determination	Fiscal Management	Notification of Eligibles/Public Information	TYPE OF AGENCY	TYPE OF RELATIONSHIP	Medical	Outreach	Follow-up	Transportation	Recordkeeping	Eligibility Determination	Fiscal Management	Notification of Eligibles/Public Information
MISSISSIPPI (IV) (Mississippi Medicaid Commission has administrative responsibility for Title XIX.)	PW	NA			X	X				X	LWB	SA			X	X	X			X
	PH	C	X	X	X						LHB	SA	X	X	X		X			
	PI	C							X											
TENNESSEE (IV)	PW	NA	X								LWB	SA		X	X			X		X
	PH	C	X								LBH	SA	X				X			
	PI	C							X											
	Dept.Ed	C	X																	
ILLINOIS (V)	PW	NA					I	X	X		LWB	SA						X		
	PH	C	X																	

PW=Public Welfare
PH=Public Health
YFS=Youth Family Services

SHA=State Health Agencies
MA=Dept. Medical Assistance
LWB=Local Welfare Board

LHB= Local Health Board
LMAU=Local Med. Asst. Unit
S=Structural Relationship

SA= State Administered
LA= Locally Administered
NA= Not Applicable

I=Informal Agreement
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CSD=Children's Servi
Division
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ability Preventi
Program

TABLE XII(cont.)

STATE/LOCAL EPSDT ORGANIZATIONAL AND RESPONSIBILITY PROFILE FOR TARGET STATES

TARGET STATES	STATE LEVEL INTERAGENCY EPSDT RELATIONSHIPS										STATE AGENCY-LOCAL GOVERNMENT AGENCY RELATIONSHIPS									
			FUNCTIONS										FUNCTIONS							
	TYPE OF AGENCY	TYPE OF RELATIONSHIP	Medical	Outreach	Follow-up	Transportation	Recordkeeping	Eligibility Determination	Fiscal Management	Notification of Eligibles/Public Information	TYPE OF AGENCY	TYPE OF RELATIONSHIP	Medical	Outreach	Follow-up	Transportation	Recordkeeping	Eligibility Determination	Fiscal Management	Notification of Eligibles/Public Information
OHIO (V)	PW	NA					X		X	X	LWB	LA	X	X	X	X	X	X		X
TEXAS (VI)	PW	NA					X			X	LWB	SA		X	X	X	X			X
	PH	C	X				X		X		LHB	SA	X							
	PI	C							X											
MISSOURI (VII) (Information incomplete)	PW	NA	X				X		X		LWB	SA	X	X	X	X	X	X		X

PW=Public Welfare
PH=Public Health
YFS=Youth Family Services

SHA=State Health Agencies
MA=Dept. Medical Assistance
LWB=Local Welfare Board

LHB= Local Health Board
LMAU=Local Med. Asst. Unit
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SA= State Administered
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TABLE XII(cont.)

STATE/LOCAL EPSDT ORGANIZATIONAL AND RESPONSIBILITY PROFILE FOR TARGET STATES

TARGET STATES	STATE LEVEL INTERAGENCY EPSDT RELATIONSHIPS										STATE AGENCY-LOCAL GOVERNMENT AGENCY RELATIONSHIPS									
			FUNCTIONS										FUNCTIONS							
	TYPE OF AGENCY	TYPE OF RELATIONSHIP	Medical	Outreach	Follow-up	Transportation	Recordkeeping	Eligibility Determination	Fiscal Management	Notification of Eligibles/Public Information	TYPE OF AGENCY	TYPE OF RELATIONSHIP	Medical	Outreach	Follow-up	Transportation	Recordkeeping	Eligibility Determination	Fiscal Management	Notification of Eligibles/Public Information
MONTANA (VIII) No state plan. (Limited information)	PW	NA							X		LWB	LA			X	X				X
	PH	C	X								LHB	SA	X							
CALIFORNIA (IX)	PW						X													
	PH	C					X				LWB	LA						X		
	PI	C							X		Local CHPD	LA	X	X	X	X	X		X	
OREGON (X) (Dept. Human Resources Public Welfare Division)	PW	NA	X	X			X		X		LWB	SA	X	X			X	X		X
											CSD	LA			X	X				

PW=Public Welfare
PH=Public Health
YFS=Youth Family Services

SHA=State Health Agencies
MA=Dept. Medical Assistance
LWB=Local Welfare Board

LHB= Local Health Board
LMAU=Local Med. Asst. Unit
S=Structural Relationship

SA= State Administered
LA= Locally Administered
NA= Not Applicable

I=Informal Agreement
C=Contractual Agreement
PI=Private Insurance

CSD=Children's Ser
Division
CHDD=Child Health D
ability Prever
Program

B. ANALYSIS OF FINDINGS: STATE/LOCAL ORGANIZATIONAL RESPONSIBILITY IN TARGET STATES

In analyzing the type of relationships that existed at the state interagency level, we found that the relationship was defined through a contractual agreement in 14 instances. Only one state, Massachusetts, had an informal agreement at this level--in this instance between the public welfare and health agency. In New Jersey, the different state level agencies involved in EPSDT were structured so that they were ultimately responsible to the state public welfare agency, but functioned as semi-autonomous units.

In reviewing the 12 target states, we found the most frequently cited* parties to interagency relationships to be the public welfare and public health agencies (eight out of twelve states). The second most frequently cited interagency relationship involved the public welfare agency and a private insurance carrier. The frequency of welfare and health agency involvement is to be expected because of the requirements of Medicaid/EPSDT. It is of particular interest, however, that at least 50% of the target states--six out of twelve--contracted with a non-governmental entity namely, a private insurance carrier such as Blue Cross, to be responsible for the fiscal management of EPSDT.

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* It is assumed that the public welfare agency is a party to the contract even where it is not specifically cited because of Title XIX requirements.

The public welfare agency was most frequently cited (ten out of 28 times) as having organizational responsibility for specific EPSDT functions. The next most frequently cited agency was the public health agency, eight out of twenty-eight times.

The medical function was most frequently found to be accomplished through an interagency agreement, thirteen times as compared to once for transportation. The states usually chose health-type units to be responsible for the medical function, e.g., public health department, state health agency, or a medical assistance unit. Since welfare agencies rarely have the resources to provide comprehensive health services, it is necessary for them to contract for the provision of such services. In some instances, e.g. Texas, the health department directly provides EPSDT services while in other states, public health agencies have the responsibility for finding providers and arranging for screening rather than directly providing such services.

In examining state and local governmental agency relationships, we found that ten out of twenty-two relationships involved the local welfare board. In seven states, however, the local board was a decentralized unit of the state public welfare agency. In such states, the local welfare board has considerable autonomy, and policies and procedures may vary from locality to locality with consequent confusion for agencies and individuals having to interact with them.

In New Jersey, the greatest proliferation of units had organizational responsibility for different EPSDT functions. An additional complication in New Jersey is that local agencies determine eligibility while the units responsible for locating providers are administered statewide.

The fact that EPSDT was primarily maintained as a state administered program is reflected in the relationships between state and local agencies. In thirteen out of twenty-two such relationships cited, the relationship involved an organizational unit that was part of the state administrative system. In six instances, the unit was under local authority and the number of contracts needed and used to define the relationship between state and local units was drastically reduced. But only one such instance occurred. (In New Jersey, a contract existed with the local health boards which are part of a state administered public health unit.)

Again, as in the case of state interagency relationships, the medical function was found to be most frequently delegated between state and local agencies--twelve out of twenty-two delegations of this nature existed. Health agencies were the primary actor at the local level.

A large degree of responsibility was also given to local units for follow-up and recordkeeping, transportation, and notification of eligibles, including public information. For instance, follow-up and recordkeeping were delegated eleven times. At the state level, in contrast, there was only one interagency agreement established for this purpose. In many cases, the actual collection of health service records was performed by the local agency but the data was maintained at both local and state levels for reporting to SRS. There is a similar shift of responsibility in the case of transportation services, ten such delegations to the local level and one state interagency agreement to provide for transportation. Overall, the table shows that the local welfare board is more frequently responsible for these non-health functions than any other local unit.*

C. CONCLUSIONS: STATE/LOCAL ORGANIZATIONAL RESPONSIBILITY IN TARGET STATES

1. The responsibility for EPSDT is diffused over many agencies and levels of government. Although the limits of the various operational responsibilities (where one agency's responsibility ends and the other begins) were not specifically analyzed, it is apparent that the operational aspects of Medicaid/EPSDT are complicated. One agency certifies eligibles, another finds providers, and another services, sometimes from the state level and, in other cases, at the local level. Identifying which agencies are responsible for various aspects of the program is often difficult since there are few clear patterns across functions and activities.

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* It can be assumed, unless otherwise specified, that eligibility determination was retained by the welfare agency.

2. Responsibility for support services seems to be vested in local governmental agencies. For instance , in 7 states the local welfare board has responsibility for follow-up. The site visits indicated that in many areas, local welfare staff felt overextended with their regular case loads and the additional responsibilities that EPSDT required made them feel even more overextended.

   Ten states made provisions for transportation, primarily assigning it to local welfare boards. Information obtained in the site visits indicated that many EPSDT recipients have difficulty even in these states in securing EPSDT sponsored transportation, although theoretically they are entitled to this service. This example is only one of many illustrating the difficulties that occur when responsibilities are diffused among many units in different ways. Moreover, the paucity of formalized relationships tends to frustrate the efforts of community agencies such as Head Start to gain access to and recognition by this system.

D. RECOMMENDATION: STATE/LOCAL ORGANIZATIONAL RESPONSIBILITY IN TARGET STATES

Information on the operational aspects of ESPDT should be provided to consumers and agencies (such as Head Start) interested in making effective use of these services.

A. PROVIDER PROVISIONS AND ATTITUDES BY SELECTED PROJECTS (TABLE XIII)

An important issue for the implementation of the EPSDT program is the extent to which providers of EPSDT services, including Head Start agencies, can achieve vendor status. Information is presented in Table XIII concerning the extent of restrictions on vendor status of Medicaid providers, reimbursement procedures, and attitudes of providers in the various target states and selected projects. The data is derived from the sources used in the previous table with particular emphasis on information obtained from the projects visited and their providers. Restrictions, for purposes of analysis, are spelled out in the states' Medicaid and EPSDT plans, respectively. Since EPSDT related treatment is often provided under Medicaid, provisions of both plans are analyzed as appropriate.

B. ANALYSIS OF FINDINGS: PROVIDER PROVISIONS AND ATTITUDES BY SELECTED PROJECTS

It was found that nine out of twelve of the target states placed restrictions on the vendor status of providers of Medicaid services*. Only three states, Ohio, California, and Oregon, imposed no such restrictions.

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* Table XIII provides data relating primarily to providers of health services; Columns A and B are an exception.

TABLE XIII

PROVIDER/VENDOR STATUS, REIMBURSEMENT PROCEDURES, AND ATTITUDES FOR TARGET STATES AND SELECTED PROJECTS

TARGET STATES AND SELECTED PROJECTS	A	B		C	D			E	
	LIMITATIONS ON VENDOR STATUS OF PROVIDERS FOR MEDICAID SERVICES	FURTHER LIMITATIONS ON PROVIDER/VENDOR AVAILABILITY FOR EPSDT CHILDREN BY SERVICE		EPSDT PARTICIPATION AGREEMENT USED	REIMBURSEMENT PROCEDURES			PROVIDER ATTITUDES TOWARD EPSDT RATES AND PRACTICES	
						Rate System			
		1 Screening	2 Treatment		1 Separate Billing/ Reporting Forms for EPSDT	2 General	3 Special for EPSDT Screening Only	1 Public	2 Private
MASSACHUSETTS (I)	L	NO	NO	Preferred	YES	FF	YES		
Leominster								NA	RD,PU,NS, SU
Worcester								NA	RD
NEW JERSEY (II)	L	NO	NO	Preferred for clinic	YES	FF, UC	YES		
Toms River									RM SU
Peterson									RU
Trenton									RU, FU
MARYLAND (III)	L	NO*	NO	NO	YES	UC	YES		*FU
Baltimore									FU
MISSISSIPPI (IV)	L	YES	YES	NA	YES	NI	FF		
Cleveland								SA	
TENNESSEE (IV)	L	YES	NO	NA	YES	NI	YES		
Kingston								C	RM,RU,PU

C - Cooperative
FU - Forms Unacceptable
NA - Not Applicable
NI - No Information
NS - Not Providing All Services
L - Limited

P - Positive
PU - Physician uninformed about EPSDT
O - Opposed to Staff Policies
RD - Reimbursement Delayed
RM - Refuse/Reluctant to serve Medicaid
U - Unlimited

RU - Rates Unacceptable
SU - Screening Practice Unacceptable
SA - Services Not Available
U - Uncooperative
FF - Fixed Fee
UC - Usual and Customary
R - Required

*Forms unacceptable and most physicians are not participating

TABLE XIII
(Cont'd.)

PROVIDER/VENDOR STATUS, REIMBURSEMENT PROCEDURES, AND ATTITUDES FOR TARGET STATES AND SELECTED PROJECTS

	A	B		C	D			E	
TARGET STATES AND SELECTED PROJECTS	RESTRICTIONS ON VENDOR STATUS OF PROVIDERS FOR MEDICAID SERVICES	FURTHER RESTRICTIONS ON PROVIDER/VENDOR AVAILABILITY FOR EPSDT CHILDREN BY SERVICE		EPSDT PARTICIPATION AGREEMENT USED	REIMBURSEMENT PROCEDURES			PROVIDER ATTITUDES TOWARD EPSDT RATES AND PRACTICES	
						Rate System			
		1 Screening	2 Treatment		1 Separate Billing/ Reporting Forms for EPSDT	2 General	3 Special for EPSDT Screening Only	1 Public	2 Private
ILLINOIS (V)	L	YES*	NO	R for Screening Center	YES	UC	FF		FU
Cook County									
East St. Louis									RD,RM,PU
Danville									FU,RM
OHIO (V)	U	NO	NO	NONE	YES	NI	U+C		
Cincinnati									RD
Dayton									P
TEXAS (VI)	L	YES	NO		YES	NI	NA		
Lubbock								P	
Amarillo								P	
Loredo (IMPD)								P	
MISSOURI (VII)	L	NO	NO	NONE	YES	NI	FF		
Appleton									FU,RM,RU

*Vendor Status for screening and hearing is restricted to the state health department

(Cont'd.)

PROVIDER/VENDOR STATUS, REIMBURSEMENT PROCEDURES, AND ATTITUDES FOR TARGET STATES AND SELECTED PROJECTS

	A	B		C	D			E	
TARGET STATES AND SELECTED PROJECTS	LIMITATIONS ON VENDOR STATUS OF PROVIDERS FOR MEDICAID SERVICES	FURTHER LIMITATIONS ON PROVIDER/VENDOR AVAILABILITY FOR EPSDT CHILDREN BY SERVICE		EPSDT PARTICIPATION AGREEMENT USED	REIMBURSEMENT PROCEDURES			PROVIDER ATTITUDES TOWARD EPSDT RATES AND PRACTICES	
						Rate System			
		1 Screening	2 Treatment		1 Separate Billing/ Reporting Forms for EPSDT	2 General	3 Special for EPSDT Screening Only	1 Public	2 Private
MISSOURI (CONT'D) Springfield *									FU,RU
MONTANA (VIII)	L	NO	NO	NO	NO	UC	NO		
Billings								SA	FU,O
Blackfeet (IMPD)								2)	O,RU
Fort Peck (IMPD)								2) U	C
CALIFORNIA (IX)	U	NO	NO	R	YES	UC	FF		
El Centro								SA	RM,RU,FU, C
Fresno (IMPD)								SA	RU,D,U
OREGON (X)	U	NO	NO	R for Screening Center	YES	NI	FF		
Eugene									RU,RU,O
Medford								C	RM,RU
TOTALS	L=9 U=3	YES=4 NO=8	YES=1 NO=11	NA=2 NO=2 NONE 2 Preferred= =1 Preferred for clinic =2 R for screening=3	YES=1 NO=11	FF=1 FF,UC=1 NI=6 UC=4	YES=4 FF=5 NA=1 U,C=1	C=2 NA=2 P=3 SA=4 1=U	See Detail

* Program did not use Medicaid Vendors.

2) Indian Health Service Provides most of services and was not reimbursed

Available information was also analyzed to determine whether there were limitations which specifically restricted the availability of providers/vendors to supply screening and treatment services for children eligible for EPSDT. There were proportionally fewer restrictions on providers/vendors treating EPSDT children. Only one state, Mississippi, reportedly imposes restrictions on treatment vendors, whereas four states--Mississippi, Tennessee, Illinois and Texas--place restrictions on vendors of screening services. In Maryland, there were no legal restrictions as to vendors screening EPSDT children. Many physicians have refused to complete the special set of EPSDT forms required by the state because they consider them a duplication of effort. Thus they are not considered EPSDT providers. However, since Maryland makes provision for preventive screening under its Medicaid plan, providers are performing screening services comparable to EPSDT, although these services are not recorded as such. In Illinois, where there are restrictions, physicians not only found the forms to be unacceptable but also disliked the bureaucratization of governmentally-funded medical services.

Three states required that providers complete an EPSDT participation agreement to screen or treat eligible children. In two of these states, Oregon and Illinois, this policy is applicable only to clinics. Two states have a preference for agreements--again for clinics--and two have no such regulation.

A number of states, however, provided for accountability measures regarding reimbursement procedures. Eleven of the twelve target states required separate billing on reporting forms for EPSDT. The rate system for reimbursement, however, allowed for much flexibility. For instance, only one state, Massachusetts, had a fixed fee for general Medicaid services and four target states permitted physicians to charge their usual or customary fee.

New Jersey allowed for both fixed and usual fees. Four states have special fees for EPSDT screening only and five states established fees for EPSDT screening at a fixed rate. One state, Missouri, had no special fee for EPSDT screening.

The twenty-five selected projects were asked their perceptions about provider attitudes toward EPSDT rates and practices. In assessing the attitudes of public providers of EPSDT services, only twelve out of the twenty-five projects responded, because in other cases, public providers were not used by the projects or were not included under the state plan. Five of these 112 projects found public providers to be either positive or cooperative in their attitudes. Four projects indicated that there were no services available from the public sector.

There was a much higher response rate regarding the attitudes of private providers, with twenty-two out of twenty-five selected projects providing information in this area. Moreover, many projects described in detail their perceptions of providers from the private sector. In toto, forty-two responses were recorded.

By and large, the projects perceived the private providers as negative in their attitude toward EPSDT. For instance, nine projects reported that the rates were unacceptable to the private sector and eight cited the forms as a source of contention.

Seven projects indicated that the private providers with whom they had contact refused or were reluctant to serve Medicaid patients. Only three projects found private providers to be positive or cooperative in their attitude. Of interest, though, is the fact that only one project felt that the private providers were uncooperative and four stated that the providers in their area were opposed to the state policy.

Comments from the selected projects reflect provider opposition to specific aspects of the EPSDT program (rates, forms, service definitions). The overall pattern is one of general resistance to EPSDT and to Medicaid. The role played by the state

A. SELECTED PROJECTS' RELATIONS WITH STATE AND LOCAL MEDICAID/EPSDT AGENCIES (TABLE XIV)

The guidelines for the Head Start/EPSDT Collaborative Effort explicitly call for Head Start to establish relationships with state and local Medicaid/EPSDT agencies in order to implement the demonstration effort. Other directives also provide for such activity.

B. ANALYSIS OF FINDINGS: RELATIONS WITH STATE/LOCAL MEDICAID/EPSDT FINDINGS

There was wide variation in the degree to which selected projects had initiated relationships with a state as opposed to a local Medicaid/EPSDT agency. A comparison of Columns A and B in Table XIV shows, for instance, that 88% (22 out of 25) of the selected projects reported that a relationship had been initiated with the local Medicaid/EPSDT agency while only 48% (12 out of 25 projects) indicated that such a contact had been made with the state unit responsible for the Medicaid/EPSDT program.

Further analysis of Table XIV shows that the Head Start program was usually responsible for initiating the relationship with the Medicaid/EPSDT agency. For example, the data in Column A indicate that of the 12 projects which reported a relationship with the state agency, seven or 58% had taken responsibility for the contact. Five projects, however, attributed the relationship with the state Medicaid/EPSDT agency

TABLE XIV

RELATIONS WITH STATE AND LOCAL MEDICAID/EPSDT AGENCIES BY SELECTED PROJECTS

SELECTED PROJECTS BY STATE	A INITIATOR OF RELATIONSHIP WITH STATE AGENCY 1 State	2 HS Program	3 Health Liaison Specialist	4 Local Agency	5 Joint	6 No One	B INITIATOR OF RELATIONSHIP WITH LOCAL AGENCY 1 State	2 HS Program	3 Health Liaison Specialist	4 Local Agency	5 Joint	6 No One	C TYPE OF RELATIONSHIP 1 Written Agreement	2 Verbal Agreement	3 Not Clarified	4 None	D OUTCOMES OF RELATIONSHIP 1 Program Assigned Vendor Number	2 Reimbursement For Full Range of Services	3 Reimbursement For Limited Services	4 Provision of Medicaid Eligibility Lists	5 Provision of Provider/ Vendor Lists	6 Provision of More Follow-up	7 Minimalization of Duplication of Efforts	8 Extensive Communication (Positive)	Minimal
ASSACHUSETTS (I): Leominster		X						X								X	N	N	N	N	N	N	N	N	L/
Worcester			X		X			X								X	N	N	N	L	S	N	N	N	L/
EW JERSEY (II): Toms River					X							X		X			N	N	N	N	N	N	L	N	L
Paterson						X		X								X	N	N	N	N	S	N	L	N	L
Trenton						X		X								X	N	N	N	N	N	N	N	N	L
ARYLAND (III): Baltimore	X		X								X			X			N	N	N	N	N	N	N	L	S
ISSISSIPPI (IV): Cleveland						X					X			X			N	N	N	L	N	N	N	N	L
ENNESSEE (IV): Kingston						X			X					X			N	N	N	L	N	N	L	L	L
LLINOIS (V): Cook County					X						X			X			N	N	N	N	L	N	N	N	L
East St. Louis						X						X				X	N	N	N	N	N	N	N	N	N
Danville						X		X								X	N	N	N	N	N	N	N	N	L
HIO (V): Cincinnati						X		X								X	N	N	N	N	N	N	N	N	L
Dayton						X		X								X	N	N	N	N	N	N	N	N	L

TABLE XIV
(Cont'd.)

RELATIONS WITH STATE AND LOCAL MEDICAID/EPSDT AGENCIES BY SELECTED PROJECTS

SELECTED PROJECTS BY STATE	A						B						C				D								
	INITIATOR OF RELATIONSHIP WITH STATE AGENCY						INITIATOR OF RELATIONSHIP WITH LOCAL AGENCY						TYPE OF RELATIONSHIP				OUTCOMES OF RELATIONSHIP								
	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	1	2	3	4	5	6	7	8	
	State	HS Program	Health Liaison Specialist	Local Agency	Joint	No One	State	HS Program	Health Liaison Specialist	Local Agency	Joint	No One	Written Agreement	Verbal Agreement	Not Clarified	None	Program Assigned Vendor Number	Reimbursement For Full Range of Services	Reimbursement For Limited Services	Provision of Medicaid Eligibility Lists	Provision of Provider/ Vendor Lists	Provision of More Follow-up	Minimalization of Duplication of Efforts	Extensive Communication (Positive)	Minimal
EXAS ((VI): Lubbock						X			X					X			N	N	N	N	N	N	N	L	N/
Amarillo						X		X						X			N	N	N	N	N	N	N	L	N/
Laredo (IMPD)						X		X						X			N	N	N	L	L	L	L	L	N/
ISSOURI (VII): Appleton						X						X		X			N	N	N	L	N	N	N	N	L
Springfield		X						X						X			N	N	N	L	N	N	N	N	S/
ONTANA (VIII): Billings		X	X								X					X	N	N	N	N	N	N	N	N	S/
Blackfeet (IMPD)	X			X						X				X			N	N	N	L	N	N	L	S/L	S
Fort Peck (IMPD)		X			X									X			N	N	N	L	N	N	N	S/L	S
ALIFORNIA (IX) El Centro						X		X								X	N	N	N	N	N	N	N	N	N
Fresno (IMPD)		X						X								X	N	N	N	N	N	N	N/A	N	S/
REGON (X): Eugene		X									X		X				S	N	N	L	N	N	S/L	S/L	N
Medford		X						X						X			N	N	N	S	N	N	N	N	S
TOTALS	2	7	3	1	3	13	-	13	2	1	6	3	1	13	-	11	N=24 S=1	N=25	L=9 N=15 S=1	L=2 N=2 S=2	L=1 N=24	L=5 N=18 N/A=1 S/L=1	L=5 N=17 S/L=3	L=5 N=17 S/L=3	L=1 L/S N=3 N/ S=1

to activity by the Health Liaison Specialist of the state unit itself.

Column B, which identifies the relationships established with the local Medicaid/EPSDT agency, shows that, in 59% or 12 of the 22 projects, contacts had been initiated by the Head Start program alone. In six instances, another agency, e.g., the Health Liaison Specialist or the local Medicaid/EPSDT agency, had shared the responsibility with the project for initiating the relationship. Two projects, on the other hand, cited the Health Liaison Specialist as being solely responsible for the relationship.

There are several factors which may have contributed to the marked difference in the nature and approach to relationships that Head Start Programs developed with the state as compared to the local Medicaid/EPSDT agency. First of all, presuming that the Head Start program perceives that maximum utilization of Medicaid resources is a means of increasing the range of services available through the program, the program could pursue this objective by initiating contact with the Medicaid/EPSDT agency most readily accessible for providing direct services. It would, therefore, be most likely to contact a local unit rather than searching for the unit through which policy changes could be negotiated. Moreover, many state agencies which are responsible for the Medicaid/EPSDT program either have decentralized program operations or have delegated part or all of the program functions to another agency at the local level (see Tables XI and XII).

In either event, however, the responsibility for making policy and setting Medicaid/EPSDT standards is usually retained at the centralized level. Therefore, the type of agreement to be established between the legal Medicaid/EPSDT agency and the Head Start Program regarding the delivery of services could, at best, be only informal with little impact upon the institutional arrangements for the delivery of Medicaid/EPSDT services. In order for institutional changes to occur, there would have to be involvement or approval of the state unit with ultimate responsibility for the Medicaid/EPSDT program.

Therefore, it is understandable that the type of agreement developed between the Head Start program and the local Medicaid/EPSDT agency tended to be informal as shown by the data in Table XIV, Column C. Thirteen out of 25 projects reported that they had only verbal agreements with the local unit and 11 projects stated that they had no type of agreement at all. Only one project, Eugene, Ore., indicated that it had a written agreement with the Medicaid/EPSDT agency and that the agreement and been in effect for years.

Furthermore, the projects themselves, as indicated in Column D, reported five significant outcomes of the relationships that had been initiated with either a state or local Medicaid/EPSDT agency. For instance, 14 or of 25 projects or 56% of those reporting, stated that the only result of the relationship was establishment of a minimal level of communication. Eight of these projects did indicate, however, that their communication with the Medicaid/EPSDT agency had become extensive, primarily with the local unit. Coordination of activities, as reflected by a decrease in duplication of effort between Head Start as a recruitment or referral agency, lessened. Only six projects indicated that the relationship with the Medicaid/EPSDT agency had minimum duplication of effort. One project stated that there was an increase in follow-up services. Ten projects did report that they were able to obtain the lists of Medicaid-eligible children and five stated that they had received the list of providers and vendors.

C. CONCLUSION: RELATIONSHIP WITH STATE/LOCAL MEDICAID/ EPSDT AGENCIES.

The data indicates that there was overall failure by the Head Start program to be fully integrated into the delivery system of Medicaid/EPSDT services at the state or local level. No project reported that it was able to be reimbursed for either a limited or full range of the EPSDT related services it may have provided and only the project in Eugene, Ore., achieved vendor status under the state Medicaid/ EPSDT program.

2. The Head Start/EPSDT Collaborative Effort had minimal, if any, impact upon the institutional arrangements of a state Medicaid/EPSDT program. Indeed it is highly unlikely that an individual Head Start program would have the power or influence to effect institutional change in the bureaucratic organization of state Medicaid/EPSDT services without external support.

D. RECOMMENDATIONS: RELATIONSHIP WITH STATE/LOCAL MEDICAID/ EPSDT AGENCIES

1. Major responsibility for establishing Head Start as an integral part of the delivery system for Medicaid/ EPSDT services, therefore, would appear to reside at the federal level. SRS, for instances, could review the utilization of Head Start in providing certain specific services rendered where appropriate. Moreover, OCD regional personnel, particularly the Health Liaison Specialists, could be more actively involved in initiating and following through on contacts to insure that formalized relationships between the Head Start program and the appropriate state or local Medicaid/EPSDT agency are established and maintained.

A. TYPES AND ADEQUACY OF TECHNICAL ASSISTANCE FOR SELECTED PROJECTS (TABLE XV)

In assessing the adequacy of technical assistance received from various sources, 56% (14 out of 25) of the selected projects, found that the help provided by the Health Liaison Specialist was more sufficient than that available from state or local Medicaid/EPSDT agencies. Five of the projects also indicated that the technical assistance from the public agencies was equally sufficient (Table XV, Column A).

The state Medicaid/EPSDT agency was more frequently cited than other agencies as not having provided any technical assistance, and one project, Toms River, N.J., stated that it had not received assistance from any source.

The selected projects were also asked about the specific type of technical assistance they had received and the source. The type of technical assistance assumed to be available ranged from meeting information and communication needs to improving program and administrative functioning. Moreover, it was expected that the Health Liaison Specialist would be primarily involved in serving informational/communicative functions and the state or local agency would be primarily responsible for assisting in those areas which required specific program expertise.

B. ANALYSIS OF FINDINGS ON TYPES AND ADEQUACY OF TECHNICAL ASSISTANCE FOR SELECTED PROJECTS.

Table XV, Column B, indicates that the most frequent type of technical assistance provided was in the form of workshop and information provision (39 out of 66 responses). Fourteen projects reported that they had received technical assistance in improving their relationship with the EPSDT agency. It should be noted that in one project--El Centro, Calif.--SRS was the source of assistance. At the other extreme, no project had received any assistance in improving its fiscal arrangements and only six had received any help in improving their supportive services.

Table XIV, Column D, indicates that no project received reimbursement for EPSDT services it may have provided. This outcome is more understandable in light of the fact that no technical assistance was given to improve fiscal arrangements.

The Health Liaison Specialist is most frequently cited as the source of technical assistance (35 out of 66 favorable responses in Table XV, Column B). The major type of technical assistance provided by the Health Liaison Specialist was through workshops and information provision. The Health Liaison Specialists were relatively active in improving relationships with the EPSDT agency (eight out of fourteen projects reporting). It is interesting to note, however, that of the eight projects reporting such assistance,

TABLE XV

TYPES AND ADEQUACY OF TECHNICAL ASSISTANCE BY SOURCE AND TECHNICAL ASSISTANCE NEEDS FOR SELECTED PROJECTS

SELECTED PROJECTS BY STATE	A			B						C					
	HEAD START PROGRAM ASSESSMENT OF ADEQUACY OF TECHNICAL ASSISTANCE BY SOURCE OF ASSISTANCE			TYPE OF ASSISTANCE RECEIVED BY SOURCE OF ASSISTANCE						TYPES OF ASSISTANCE NEEDS IDENTIFIED					
	1	2	3	1	2	3	4	5	6	1	2	3	4	5	6
	Sufficient	Insufficient	None	Workshops and. Information	Improving Relationship with EPSDT Agencies	Improving Health Services	Improving Supportive Services	Improving Fiscal Arrangements	Improving Planning and Administration	Workshops and Information	Relationship with EPSDT Agencies	Health Services	Supportive Services	Fiscal Arrangements	Planning and
ASSACHUSETTS (I):															
Leominster	SA,LA		HLS	SA,LA	SA,LA	–	–	–	–	X		X	X		
Worcester	HLS SA LA			HLS,SA	SA, LA	-	-	-	-	-	-	-	X	-	X
W JERSEY (II):															
Toms River			HLS,SA, LA	-	-	-	-	-	-	X	X	X	X	X	
Paterson		HLS	LA,SA	HLS	-	-	-	-	-	-	X		X	X	
Trenton		HLS	SA,LA	HLS	-	-	-	-	-	-	X	-	-	X	

CODE:

HLS = Health Liaison Specialist
SA = State Agencies
LA = Local Agencies

TABLE XV
(Cont'd.)

TYPES AND ADEQUACY OF TECHNICAL ASSISTANCE BY SOURCE AND TECHNICAL ASSISTANCE NEEDS FOR SELECTED PROJECTS

	A			B						C					
	HEAD START PROGRAM ASSESSMENT OF ADEQUACY OF TECHNICAL ASSISTANCE BY SOURCE OF ASSISTANCE			TYPE OF ASSISTANCE RECEIVED BY SOURCE OF ASSISTANCE						TYPES OF ASSISTANCE NEEDS IDENTIFIED					
SELECTED PROJECTS BY STATE	1 Sufficient	2 Insufficient	3 None	1 Workshops and Information	2 Improving Relationship with EPSDT Agencies	3 Improving Health Services	4 Improving Supportive Services	5 Improving Fiscal Arrangements	6 Improving Planning and Administration	1 Workshops and Information	2 Relationship with EPSDT Agencies	3 Health Services	4 Supportive Services	5 Fiscal Arrangements	6 Planning and
RYLAND (III): Baltimore	SA	HLS, LA		HLS, LA	HLS	-	-	-	-	X	X	X	X	X	
SSISSIPPI (IV): Cleveland	HLS, LA		SA	HLS, LA	-	-	-	-	HLS	X	X	X	X	X	X
NNESSEE (IV): Kingston	HLS, SA, LA			HLS	HLS	LA	-	-	HLS, LA	X	-	X	-	-	X
LINOIS (V): Cook County	LA	HLS	SA	HLS, LA	LA	-	-	-	LA	X	X	X	X	X	X
East St. Louis		HLS	SA, LA	HLS	_	_	_	_	_	X	X	-	X	X	X

CODE:

HLS = Health Liaison Specialist
SA = State Agencies
LA = Local Agencies

TABLE XV
(Cont'd.)

TYPES AND ADEQUACY OF TECHNICAL ASSISTANCE BY SOURCE AND TECHNICAL ASSISTANCE NEEDS FOR SELECTED PROJECTS

SELECTED PROJECTS BY STATE	A			B						C					
	HEAD START PROGRAM ASSESSMENT OF ADEQUACY OF TECHNICAL ASSISTANCE BY SOURCE OF ASSISTANCE			TYPE OF ASSISTANCE RECEIVED BY SOURCE OF ASSISTANCE						TYPES OF ASSISTANCE NEEDS IDENTIFIED					
	1 Sufficient	2 Insufficient	3 None	1 Workshops and Information	2 Improving Relationship with EPSDT Agencies	3 Improving Health Services	4 Improving Supportive Services	5 Improving Fiscal Arrangements	6 Improving Planning and Administration	1 Workshops and Information	2 Relationship with EPSDT Agencies	3 Health Services	4 Supportive Services	5 Fiscal Arrangements	6 Planning and
LINOIS (Cont'd.) Danville	HLS		SA, LA	HLS	-	-	-	-	-	X	X	-	X	-	-
IO (V): Cincinnati	HLS		SA, LA	HLS	-	-	-	-	-	X	X	-	X	-	X
Dayton	HLS		SA, LA	HLS	-	-	-	-	-	X	X	X	X	X	X
XAS (VI): Lubbock	HLS		SA*	HLS	HLS	-	HLS	-	-	X			X	X	X
Amarillo	HLS		SA*	HLS	-	-	-	-	-	X			X		

*District Welfare Agengies in Texas are administered by the State.

CODE:
HLS = Health Liaison Specialist
SA = State Agencies
LA = Local Agencies

TABLE XV
(Cont'd.)

TYPES AND ADEQUACY OF TECHNICAL ASSISTANCE BY SOURCE AND TECHNICAL ASSISTANCE NEEDS FOR SELECTED PROJECTS

SELECTED PROJECTS BY STATE	A			B						C					
	HEAD START PROGRAM ASSESSMENT OF ADEQUACY OF TECHNICAL ASSISTANCE BY SOURCE OF ASSISTANCE			TYPE OF ASSISTANCE RECEIVED BY SOURCE OF ASSISTANCE						TYPES OF ASSISTANCE NEEDS IDENTIFIED					
	1 Sufficient	2 Insufficient	3 None	1 Workshops and Information	2 Improving Relationship with EPSDT Agencies	3 Improving Health Services	4 Improving Supportive Services	5 Improving Fiscal Arrangements	6 Improving Planning and Administration	1 Workshops and Information	2 Relationship with EPSDT Agencies	3 Health Services	4 Supportive Services	5 Fiscal Arrangements	6 Planning and
XAS (Cont'd.) Laredo (IMPD)	HLS, SA *			HLS	LA	—	LA	-	LA	X			X		
SSOURI (VII): Appleton	SA,LA	HLS		HLS, SA,LA	LA	-	LA	-	-	X		X	X		X
Springfield	SA,LA	HLS		HLS, SA, LA	-	-	-	-	-	X	X	X	X	X	X
NTANA (VIII): Billings	HLS	SA, LA		HLS, SA, LA	-	-	-	-	-	X	X		X	X	X
Blackfeet (IMPD)	HLS, SA, LA			HLS	HLS	SA	LA	-	-	X	X	X	X	X	X

*Local Welfare Agencies in Texas are admistered by the State

CODE:

HLS = Health Liaison Specialist
SA = State Agencies
LA = Local Agencies

TABLE XV
(Cont'd.)

TYPES AND ADEQUACY OF TECHNICAL ASSISTANCE BY SOURCE AND TECHNICAL ASSISTANCE NEEDS FOR SELECTED PROJECTS

SELECTED PROJECTS BY STATE	A			B						C				
	HEAD START PROGRAM ASSESSMENT OF ADEQUACY OF TECHNICAL ASSISTANCE BY SOURCE OF ASSISTANCE			TYPE OF ASSISTANCE RECEIVED BY SOURCE OF ASSISTANCE						TYPES OF ASSISTANCE NEEDS IDENTIFIED				
	1	2	3	1	2	3	4	5	6	1	2	3	4	5
	Sufficient	Insufficient	None	Workshops and Information	Improving Relationship with EPSDT Agencies	Improving Health Services	Improving Supportive Services	Improving Fiscal Arrangements	Improving Planning and Administration	Workshops and Information	Relationship with EPSDT Agencies	Health Services	Supportive Services	Fiscal Arrangements
MONTANA (Cont'd.)														
Fort Peck (IMPD)		HLS, SA, LA		HLS, SA, LA	HLS	-	LA	-	-	X	X	X	X	X
CALIFORNIA (IX):														
El Centro	HLS		SA, LA	HLS	SRS	-	-	-	.		X	X	X	X
Fresno (IMPD)	HLS	SA, LA		HLS, SA, LA	HLS	HLS	-	-	-	X	X	X	X	X
OREGON (X):														
Eugene	HLS	SA, LA		HLS	HLS	-	HLS	-	-			X	X	
Medford		HLS, SA, LA		HLS	HLS	-	-	-	-	X	X	X	X	X
TOTALS	HLS=9 HLS, LA=2 HLS, LA, SA=3 LA=1 LA, SA=3	HLS=6 HLS, LA=1 HLS, LA, SA=2 LA, SA=3	HLS=1 HLS, LA, SA=1 LA, SA=7	HLS=14 HLS, LA =3 HLS, LA, SA=5 LA, SA=	HLS=9 LA=3 LA, SA= 2	HLS=1 LA=1 SA=1	HLS=2 LA=4	-	HLS=1 HLS, LA =1 LA=2	20	17	15	23	16

Code:
LA= Local Agency
SA= State Agency
HLS= Health Liaison

three had initiated the relationship with the EPSDT agency on their own (Table XIV, Columns A and B).

The minimal amount of technical assistance provided by various sources beyond workshops and information strongly suggests the reason why Head Start programs failed to change institutional arrangements in their relationship with EPSDT agencies.

A substantial proportion (14) of the selected projects found the Health Liaison Specialist to be sufficient in providing technical assistance. Yet, the major type of assistance provided by the specialist was at the informational level. This attitude may reflect a hesitancy to criticize the specialist. It may also be attributable to the fact that either the Head Start programs had very little understanding of the objectives of the collaborative effort, particularly regarding their role; or there was a lack of awareness about the technical assistance that could be obtained from the Health Liaison Specialist or other sources. One is thus led to question the kind of information actually provided to the projects from whatever source.

Of equal significance is the minimal role played by the state and local Medicaid/EPSDT in providing technical assistance. Most state plans specifically call for technical assistance activity by the EPSDT agency ranging from improving outreach and supportive services to enhancing the capacity of providers to deliver hard services. It is conceivable that the state and local EPSDT agencies did not appreciate the role to be played by Head Start programs in the Medicaid/EPSDT program and therefore exercised little initiative in offering technical assistance.

As part of the evaluative study, Boone, Young & Associates' staff sought to identify the technical assistance needs of the selected projects during the on-site visits. This aspect of the site visits was not specifically addressed as such with the projects, and the data in Column C of Table XV therefore represents the judgment of the staff as to the overall operation of the collaborative effort and the informational needs of the projects as viewed by responses to specific questions, familiarity with the EPSDT objectives, and observations of the various procedures set up to implement the effort.

Twenty out of 25 projects were found to need workshops and information. Of these 20 projects, 19 stated that they had received this type of technical assistance, which suggests that there was need for additional help. Of even greater significance is the fact that 11 of the 20 stated that the workshop and information had been provided by the Health Liaison Specialist. Further, they had found the specialist to be sufficient. One may conclude, therefore, that the projects had low expectations for the conduct of the workshops and provision of information.

The evaluation staff also found that a large majority, 21 out of 25 selected projects, need technical assistance in improving their planning and administration, and an even greater number need help in improving their supportive services.

C. CONCLUSIONS ON TYPES AND ADEQUACY OF TECHNICAL ASSISTANCE FOR SELECTED PROJECTS.

1. Head Start projects indicated that the technical assistance which they received for implementing the EPSDT effort tended to be less than adequate. To the degree that any source was helpful, the Health Liaison Specialist was more frequently cited. State Medicaid/EPSDT agencies, on the other hand, were usually no source of technical assistance at all.

2. The most frequent type of technical assistance provided was in the form of workshop and information provision. No project, however, received assistance in making fiscal arrangements and few indicated that they had been assisted in implementing other administrative procedures.

D. RECOMMENDATIONS ON TYPES AND ADEQUACY OF TECHNICAL ASSISTANCE FOR SELECTED PROJECTS.

1. OCD should initiate for the second year effort a specific program of training and technical assistance to enable the Head Start projects to carry out the EPSDT Collaborative Effort more effectively. Administration and planning, as well as the development of coordinative linkages with state EPSDT agencies, should be areas of concentration.
2. The role of the Health Liaison Specialist should be more clearly defined in regard to its ongoing technical assistance function and as a liaison between the Head Start project and the state EPSDT agency.

COST IMPACT OF THE HEAD START/EPSDT COLLABORATION EFFORT

Introduction

One of the purposes of the Head Start/EPSDT Collaboration Effort is to assess the cost impact of the effort on the participating demonstration projects. Focus is also to be placed on the impact/quantifiable outcomes of the effort regarding reimbursement revenues and the particular revenue sources used by the various projects to support the effort. The following tables were, therefore, designed by Boone, Young & Associates to record and analyze information germane to the cost aspects of the effort.

- Table XIX - Cost Per Child Re: Head Start/ EPSDT Collaborative Effort by Aggregated Totals
- Table XIXA - Cost Per Child Re: Head Start/EPSDT Collaborative Effort by Selected Projects
- Table XX - Effect of EPSDT on Shifts in Head Start Expenditures by Aggregated Totals
- Table XXA - Effect of EPSDT on Shifts in Head Start Expenditures by Selected Projects
- Table XXI - Revenue Sources Used to Support EPSDT Effort by Aggregated Totals
- Table XXIA - Revenue Sources Used to Support EPSDT Effort by Selected Projects
- Table XXII - Revenue Sources Used to provide Screening and Medical Services by Selected Projects
- Table XXIII - Assessed Value of Services by Selected Projects
- Table XXIV - Per Cent Distribution of Assessed Value of Health Services by Type to Total for Selected Projects

- Table XXV - Averaged Assessed Value of Health Services by Type for Selected Projects.

It should be noted that none of the above tables will show any information at this time.

Because of the poor response by the demonstration projects to both the Head Start/EPSDT Income Sources Form and the Head Start/EPSDT Expenditure Form, a definitive analysis of Tables XIX through XXII cannot be made at this point. In addition, Tables XXIII through XXV, regarding the assessed value of services, cannot be analyzed. Data applicable to these tables must be obtained from the Health Care Encounter Form. A comprehensive data processing program is still in the process of being finalized to extract quantitative information requisite to the evaluation of the Health Care Encounter Form and the analysis of the applicable tables.

As of July 15, a total of 34 (17%) of the 198 projects had submitted the income form. Seven of the 34 projects reporting were selected projects. Even fewer projects responded to the expenditure form. Only 26 projects (12% of the universe of 198) forwarded information requested via this instrument. Of the 26 projects reporting, two were projects selected for in-depth analysis.

Boone, Young & Associates has been engaged in follow-up on those projects which have not forwarded the aforementioned forms. Letters and telephone calls have been addressed to these projects. In each instance the project has been requested/encouraged to complete and return the forms as soon as possible. It is anticipated that more revenue and expenditure forms will be received from the various demonstration projects subsequent to this report. Hopefully, these, along with those already obtained, will constitute a representative number for analysis purposes.

An explanation of each of the cost tables follows:

Table XIX

This table arrays data from the Head Start/EPSDT Expenditure Form to show the average cost per child by region. Table XIX also shows:

- the amount of the Head Start grant (including the EPSDT supplemental grant)
- the amount and percentage of the grant expended for EPSDT services to children and their families

Cost per child is calculated by dividing the total number of children within each region served into the total amount expended for each region.

A comparative analysis of cost per child will be made between the various regions. Any large disparity in cost per child will be qualified. However, given the limited information collected on the projects regarding cost, it should be noted that any conclusions drawn may be general and somewhat subjective.

Table XIX-A

This table addresses the same issues in Table XIX, but is applicable to the selected projects only. A comparative analysis of cost per child between projects will also be done here. Comparisons of cost per child by project vs. The National average (cost per child) will also be made.

Table XX

Information applicable to shifts in Head Start expenditures as a result of the Head Start/EPSDT Collaboration Effort will be shown in this table. The effect of the effort on Head Start expenditures will be arrayed according to direct, supportive,and indirect costs by region (categories are defined below). The possible effects within each of the aforementioned categories are: increase in expenditures; decrease in expenditures; no effect; and effect unknown.

Direct costs are defined as those costs which are directly ascribable to medical services rendered to children and their families involved in the Head Start/EPSDT program;

> e.g. salaries - those wages paid to staff directly involved in rendering medical units of service to children (and their families) engaged in Head Start/EPSDT; cost of supplies used in the course of administering direct health services; etc.

Supportive costs are those costs which are attributable to quality and ongoing services to children and their families participating in the Head Start/EPSDT effort;

> e.g. salaries - those wages paid to staff personnel who are not directly serving patients, but perform functions which induce better or continuity of services to patients. This could include wages paid to the outreach staff; wages paid to staff involved in parent and children education; etc.

Indirect costs are those costs which support overall program operations, but are not directly related to medical or supportive services regarding children and their families;

> e.g. salaries - those wages paid to staff personnel engaged in administrative services; cost of materials used in rendering the administrative affairs of the Head Start/EPSDT Effort; etc.

Analysis of this table will show how Head Start dollars were reallocated as a result of the Head Start/EPSDT Collaborative Effort;

e.g., more/less outreach; more/less health services to children and families participating in the collaborative effort; etc.

Table XXA

This table will reflect the same information as recorded in Table XX, but will focus exclusively on those projects selected for an in-depth analysis. Analysis of this table will be analogous with the approach in Table XX. In addition, the effect (if any) the reallocation of monies had on the overall activities of the program will be analyzed.

Table XXI

Revenue sources used by the various demonstration projects to support the Head Start/EPSDT Effort will be shown in this table. Information will be taken from the Income Sources Form and arrayed by region to indicate the extent to which each region made maximum use of all available resources regarding the implementation of Head Start/EPSDT.

This table outlines six possible sources of revenue that may have been used by the demonstration projects in support of the effort. These are:

- Governmental - amount of monies received/earned through federal, state and local grants in connection with the Head Start/EPSDT Collaborative Effort .

- Third Party Payors - amount of monies received/earned through third-party payors such as Medicaid and other such purchase of service agreements that have been reached.
- Direct Patient Payments - amount of dollars received/earned through direct payments made by families on behalf of children participating in the collaborative effort.
- Cash Contribution - amount of unearned income from voluntary contributions, e.g. foundations, endowments, etc.
- Donated Services and Materials - the assessed value of in-kind support from non-cash donations, e.g. volunteer personnel services, materials and other contributions of a non-cash nature which are incremental to program services.
- Other Revenue - amount of any other revenue from income--earning efforts such as sales, interest, etc.--not previously listed.

Analysis (by region) of the above table will ascertain if any correlation exists between the amount of revenue on hand and the number of patients served. This correlation will, of course, be subject to the unit cost per patient, as the unit cost per patient may have a material effect on the expiration of revenue sources.

Table XXI-A

Information shown in this table will be arrayed in the same manner as that reflected in Table XXI, but for the selected projects only. As in Table XXI, analysis will also focus on the correlation, if any, between revenue on hand and the number of patients served.

Table XXII

This table will be omitted.

Table XXIII

This table solicits information from the Health Care Encounter Form. Information is arrayed by selected projects to show the assessed value of services for the following:

- medical services
- dental services
- mental health services
- nutritional services.

Within each of the above categories there is a further division which focuses on the particular medical unit of service received. These are:

- screening
- diagnosis
- treatment.

The number of children receiving screening, diagnosis, and treatment; the assessed value of each of the medical units of service; and the assessed value per child then follows within each of the aforementioned medical units of service.

The assessed value per child is calculated by dividing the number of children served into the assessed value of services received.

Assessed value of services is defined as the going rate in the community that one would pay for a particular medical unit of service.

An analysis of this table will be made to explain any discrepancies in assessed value of services from project to project.

Table XXIV

This table reports the per cent distribution of assessed value of health services by type to the total assessed value of all health services. Information for this table is to be taken from Table XXIII and is attributable to the selected projects only. This table will show where the concentration of dollars for EPSDT services fall.

> Note: Information reported on this table will be aggregated for the selected projects

Table XXV

This table arrays data for the selected projects regarding the average assessed value of health services by type. Information for this table is also taken from Table XXIII.

Note: Information shown on this table will be aggregated for the selected projects

TABLE XIX

COST PER CHILD RE: HEAD START/EPSDT

AGGREGATED TOTALS: NATION, SELECTED PROJECTS, OTHER PROJECTS, REGIONS	GRANT AMOUNT	% AND AMOUNT OF GRANT EXPENDED FOR EPSDT		NUMBER OF CHILDREN SERVED (INCL. HS & NHS	COST PER CHILD	COMMENTS
		%	AMOUNT			
NATIONAL						
SELECTED PROJECTS						
ALL OTHER PROJECTS						
REGION:						
I						
II						
III						
IV						
V						
VI						
VII						
VIII						
IX						
X						
IMPD						

TABLE XIX-A

COST PER CHILD RE: HEAD START/EPSDT

SELECTED PROJECTS BY STATE	NUMBER OF PROJECTS PARTICIPATING	NUMBER OF PROJECTS REPORTING	GRANT AMOUNT	% AND AMOUNT OF GRANT EXPENDED FOR EPSDT		NUMBER OF CHILDREN SERVED INCLUDING HS & NHS	COST PER CHILD	COMMENTS
				%	Amount			
TOTAL FOR SELECTED PROJECTS								
ASSACHUSETTS (I): Leominster								
Worcester								
EW JERSEY (II): Toms River								
Paterson								
Trenton								
ARYLAND (III): Baltimore								
ISSISSIPPI (V): Cleveland								
ENNESSEE (IV): Kingston								
LLINOIS (V): Cook County								
East St. Louis								
Danville								
IIO (V): Cincinnati								
Dayton								
EXAS (VI): Lubbock								

TABLE XIX-A

COST PER CHILD RE: HEAD START/EPSDT

SELECTED PROJECTS BY STATE	NUMBER OF PROJECTS PARTICIPATING	NUMBER OF PROJECTS REPORTING	GRANT AMOUNT	% AND AMOUNT OF GRANT EXPENDED FOR EPSDT		NUMBER OF CHILDREN SERVED INCLUDING HS & NHS	COST PER CHILD	COMMENTS
				%	Amount			
OTAL FOR SELECTED PROJECTS								
EXAS (cont'd) Amarillo								
Laredo (IMPD)								
ISSOURI (VII): Appleton								
Springfield								
ONTANA (VIII): Billings								
Blackfeet (IMPD)								
Fort Peck (IMPD)								
ALIFORNIA (IX): El Centro								
Fresno								
REGON (X): Eugene								
Medford								

TABLE XX

EFFECT OF EPSDT ON SHIFTS IN HEAD START EXPENDITURES

AGGREGATED TOTALS: NATION, SELECTED PROJECTS, OTHER PROJECTS, REGIONS	DIRECT COST				SUPPORTIVE COSTS				INDIRECT COSTS			
	AMOUNT OF INCREASE	AMOUNT OF DECREASE	NO EFFECT (✓)	EFFECT UNKNOWN (✓)	AMOUNT OF INCREASE	AMOUNT OF DECREASE	NO EFFECT (✓)	EFFECT UNKNOWN (✓)	AMOUNT OF INCREASE	AMOUNT OF DECREASE	NO EFFECT (✓)	EFFECT UNKNOWN (✓)
NATIONAL												
SELECTED PROJECTS												
ALL OTHER PROJECTS												
REGION:												
I												
II												
III												
IV												
V												
VI												
VII												
VIII												
IX												
X												
IMPD												

TABLE XX-A

EFFECT OF EPSDT ON SHIFTS IN HEAD/START EXPENDITURES

SELECTED PROJECTS BY STATE	NO. OF PROJECTS REPORTING	NO. OF PROJECTS PARTIC-IPATING	DIRECT COSTS				SUPPORTIVE COSTS				INDIRECT COSTS			
			AMOUNT OF INCREASE	AMOUNT OF DECREASE	NO EFFECT (✓)	EFFECT UNKNOWN (✓)	AMOUNT OF INCREASE	AMOUNT OF DECREASE	NO EFFECT (✓)	EFFECT UNKNOWN (✓)	AMOUNT OF INCREASE	AMOUNT OF DECREASE	NO EFFECT (✓)	EFFECT UNKNOWN (✓)
TOTALS FOR SELECTED PROJECTS														
MASSACHUSETTS (I): Leominster														
Worcester														
NEW JERSEY (II): Toms River														
Paterson														
Trenton														
MARYLAND (III): Baltimore														
MISSISSIPPI (IV): Cleveland														
TENNESSEE (IV): Kingston														
ILLINOIS (V): Cook County														
East st. Louis														
Danville														
OHIO (V): Cincinnati														
Dayton														
TEXAS (VI): Lubbock														

TABLE XX-A

EFFECT OF EPSDT ON SHIFTS IN HEAD START EXPENDITURES

SELECTED PROJECTS BY STATE	NO. OF PROJECTS REPORTING	NO. OF PROJECTS PARTIC-IPATING	DIRECT COSTS				SUPPORTIVE COSTS				INDIRECT COSTS			
			AMOUNT OF INCREASE	AMOUNT OF DECREASE	NO EFFECT (✓)	EFFECT UNKNOWN (✓)	AMOUNT OF INCREASE	AMOUNT OF DECREASE	NO EFFECT (✓)	EFFECT UNKNOWN (✓)	AMOUNT OF INCREASE	AMOUNT OF DECREASE	NO EFFECT (✓)	EFFECT UNKNOWN (✓)
TOTALS FOR SELECTED PROJECTS														
TEXAS (VI):Contd Amarillo														
Loredo (IMPD)														
MISSOURI (VII): Appleton														
Springfield														
MONTANA (VIII): Billings														
Blackfeet(IMPD)														
Fort Peck(IMPD)														
CALIFORNIA (IX): El Centro														
Fresno														
OREGON (X): Eugene														
Medford														

TABLE XXI

REVENUE SOURCES USED TO SUPPORT EPSDT EFFORT

AGGREGATED TOTALS: NATION, SELECTED PROJECTS, OTHER PROJECTS, REGIONS	HEAD START FUNDS			THIRD PARTY		DIRECT PATIENT PAYMENTS	CASH CONTRIBUTIONS			IN-KIND CONTRIBUTIONS		OTHER	TOTAL ALL REVENUE SOURCES
	FEDERAL	STATE	LOCAL	XIX	OTHER		FOUNDA-TIONS	ENDOW-MENTS	PRIVATE	SERVICES	MATERIALS		
NATIONAL													
SELECTED PROJECTS													
ALL OTHER PROJECTS													
REGION I													
II													
III													
IV													
V													
VI													
VII													
VIII													
IX													
X													
IMPD													

TABLE XXI-A

REVENUE SOURCES USED TO SUPPORT EPSDT EFFORT

SELECTED PROJECTS BY STATE	NUMBER OF PROJECTS PARTICIPATING	NUMBER OF PROJECTS REPORTING	HEAD START FUNDS			THIRD PARTY		DIRECT PATIENT PAYMENTS	CASH CONTRIBUTIONS			IN-KIND CONTRIBUTIONS		OTHER	TOTAL ALL REVEN SOURCES
			FEDERAL	STATE	LOCAL	XIX	OTHER		FOUNDA-TIONS	ENDOW-MENTS	PRIVATE	SERVICES	MATERIALS		
TOTALS FOR SELECTED PROJECTS															
MASSACHUSETTS (I): Leominster															
Worcester															
NEW JERSEY (II): Toms River															
Paterson															
Trenton															
MARYLAND (III): Baltimore															
MISSISSIPPI (IV): Cleveland															
TENNESSEE (IV): Kingston															
ILLINOIS (V): Cook County															
East St. Louis															
Danville															
OHIO (V): Cincinnati															
Dayton															
TEXAS (VI): Lubbock															

TABLE XXI-A

REVENUE SOURCES USED TO SUPPORT EPSDT EFFORT

SELECTED PROJECTS BY STATE	NUMBER OF PROJECTS PARTICIPATING	NUMBER OF PROJECTS REPORTING	HEAD START FUNDS			THIRD PARTY		DIRECT PATIENT PAYMENTS	CASH CONTRIBUTIONS			IN-KIND CONTRIBUTIONS		OTHER	TOTAL ALL REVEN SOURCES
			FEDERAL	STATE	LOCAL	XIX	OTHER		FOUNDA-TIONS	ENDOW-MENTS	PRIVATE	SERVICES	MATERIALS		
TOTALS FOR SELECTED PROJECTS															
TEXAS (cont'd) Amarillo															
Laredo (IMPD)															
MISSOURI (VII): Appleton															
Springfield															
MONTANA (VIII): Billings															
Blackfeet (IMPD)															
Fort Peck (IMPD)															
CALIFORNIA (IX): El Centro															
Fresno															
OREGON (X): Eugene															
Medford															

ASSESSED VALUE OF SERVICES

TABLE XXIII

SELECTED PROJECTS	MEDICAL								
	SCREENING			DIAGNOSIS			TREATMENT		
	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD
MASSACHUSETTS (I): Leominster									
Worcester									
NEW JERSEY (II): Toms River									
Paterson									
Trenton									
MARYLAND (III): Baltimore									
MISSISSIPPI (IV): Cleveland									
TENNESSEE (IV): Kingston									
ILLINOIS (V): Cook County									
East St. Louis									
Danville									
OHIO (V): Cincinnati									
Dayton									
TEXAS (VI): Lubbock									
Amarillo									
Loredo (IMPD)									

ASSESSED VALUE OF SERVICES

TABLE XXIII(cont'd)

SELECTED PROJECTS	MEDICAL								
	SCREENING			DIAGNOSIS			TREATMENT		
	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD
MISSOURI (VII): Appleton									
Springfield									
MONTANA (VIII): Billings									
Blackfeet (IMPD)									
Fort Peck (IMPD)									
CALIFORNIA (IX): El Centro									
Fresno									
OREGON (X): Eugene									
Medford									

ASSESSED VALUE OF SERVICES

TABLE XXIII(cont'd)

SELECTED PROJECTS	DENTAL								
	INITIAL ASSESSMENT			ONGOING TREATMENT			TREATMENT ACUTE		
	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD
MASSACHUSETTS (I): Leominster									
Worcester									
NEW JERSEY (II): Toms River									
Paterson									
Trenton									
MARYLAND (III): Baltimore									
MISSISSIPPI (IV): Cleveland									
TENNESSEE (IV): Kingston									
ILLINOIS (V): Cook County									
East St. Louis									
Danville									
OHIO (V): Cincinnati									
Dayton									
TEXAS (VI): Lubbock									
Amarillo									
Loredo (IMPD)									

ASSESSED VALUE OF SERVICES

TABLE XXIII(cont'd)

SELECTED PROJECTS	DENTAL								
	INITIAL ASSESSMENT			ONGOING TREATMENT			TREATMENT ACUTE		
	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD
MISSOURI (VII): Appleton									
Springfield									
MONTANA (VIII): Billings									
Blackfeet (IMPD)									
Fort Peck (IMPD)									
CALIFORNIA (IX): El Centro									
Fresno									
OREGON (X): Eugene									
Medford									

ASSESSED VALUE OF SERVICES

TABLE XXXIII (cont'd.)

SELECTED PROJECTS	MENTAL HEALTH								
	PSYCHOLOGICAL TESTING			REFERRAL			COUNSELING		
	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD
MASSACHUSETTS (I): Leominster									
Worcester									
NEW JERSEY (II): Toms River									
Paterson									
Trenton									
MARYLAND (III): Baltimore									
MISSISSIPPI (IV): Cleveland									
TENNESSEE (IV): Kingston									
ILLINOIS (V): Cook County									
East St. Louis									
Danville									
OHIO (V): Cincinnati									
Dayton									
TEXAS (VI): Lubbock									
Amarillo									
Loredo (IMPD)									

TABLE XXXIII (cont'd.)

ASSESSED VALUE OF SERVICES

SELECTED PROJECTS	MENTAL HEALTH								
	PSYCHOLOGICAL TESTING			REFERRAL			COUNSELING		
	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD
MISSOURI (VII): Appleton									
Springfield									
MONTANA (VIII): Billings									
Blackfeet (IMPD)									
Fort Peck (IMPD)									
CALIFORNIA (IX): El Centro									
Fresno									
OREGON (X): Eugene									
Medford									

TABLE XXXIII (cont'd.)

ASSESSED VALUE OF SERVICES

SELECTED PROJECTS	NUTRITION								
	FURTHER ASSESSMENT			DIAGNOSIS			TREATMENT		
	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD
MASSACHUSETTS (I): Leominster									
Worcester									
NEW JERSEY (II): Toms River									
Paterson									
Trenton									
MARYLAND (III): Baltimore									
MISSISSIPPI (IV): Cleveland									
TENNESSEE (IV): Kingston									
ILLINOIS (V): Cock County									
East St. Louis									
Danville									
OHIO (V): Cincinnati									
Dayton									
TEXAS (VI): Lubbock									
Amarillo									
Loredo (IMPD)									

TABLE XXXIII (cont'd.)

ASSESSED VALUE OF SERVICES

SELECTED PROJECTS	NUTRITION								
	FURTHER ASSESSMENT			DIAGNOSIS			TREATMENT		
	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD	NO. OF CHILDREN	ASSESSED VALUE	ASSESSED VALUE PER CHILD
MISSOURI (VII): Appleton									
Springfield									
MONTANA (VIII): Billings									
Blackfeet (IMPD)									
Fort Peck (IMPD)									
CALIFORNIA (IX): El Centro									
Fresno									
OREGON (X): Eugene									
Medford									

TABLE XXIV

PERCENT DISTRIBUTION OF ASSESSED VALUE OF HEALTH SERVICES BY TYPE TO TOTAL

ASSESSED VALUE OF ALL HEALTH SERVICES = 100%

Medical	
Screening	___
Diagnosis	___
Treatment	___
TOTAL	═══
Dental	
Initial	___
Ongoing Treatment	___
Treatment Acute	___
TOTAL	═══
Mental Health	
Psychological Testing	___
Referral	___
Counseling	___
TOTAL	═══
Nutrition	
Further Assessment	___
Diagnosis	___
Treatment	___
TOTAL	═══

TABLE XXV

AVERAGE ASSESSED VALUE OF HEALTH SERVICES BY TYPE

AVERAGE ASSESSED VALUE OF ALL HEALTH SERVICES =

Medical

Screening ______

Diagnosis ______

Treatment ______

TOTAL ======

Dental

Initial ______

Ongoing Treatment ______

Treatment Acute ______

TOTAL ======

Mental Health

Psychological Testing ______

Referral ______

Counseling ______

TOTAL ======

Nutrition

Further Assessment ______

Diagnosis ______

Treatment ______

TOTAL ======

VII. PROBLEMS

This section provides an overview of some of the problems encountered regarding the implementation of the Head Start/EPSDT Collaborative Effort. It should be noted that this section does not attempt to cover all the problems concerning EPSDT; rather it touches on those issues found to be recurring and of general concern to a number of the demonstration projects.

Also, no attempt was made to identify specific problems of any given project. However, a more definitive analysis of problems as they relate to particular projects, regions, etc. will be made at a later date and included in the final report.

The topical areas covered in this section are:

- Lack of Understanding of Head Start/EPSDT Collaborative Effort
- Lack of Collaboration Between Programs and Welfare Agencies
- Provider Attitudes and Practices
- State Plans
- Management
- Outreach
- Follow-up
- Recordkeeping
- Transportation
- Parental Involvement

Lack of Understanding of Head Start/EPSDT Collaborative Effort

The extensive lack of understanding of the collaborative effort seriously hampered the ability of programs to fulfill their roles. Implicit within the EPSDT collaborative effort was a mandate for the development of a working relationship between Head Start and the state/local Medicaid agencies. The absence of this working relationship is rooted in the disparity that existed between how each of the participants viewed their involvement in the EPSDT effort. This lack of understanding of the meaning of "collaborative effort" was illustrated in a number of ways by both the programs and the agencies.

PROBLEMS RELATED TO PROGRAM PERSPECTIVE

- There was lack of awareness on the part of the programs concerning the role of the Medicaid agencies. Programs did not understand that agencies
    - were to act as a resource in enlisting health vendors
    - were to act as a catalyst in the community re: EPSDT
    - were to provide information/assistance regarding reimbursement practices, EPSDT objectives, etc.
- Programs perceive the Medicaid agencies as a payment source only; they did not recognize the Medicaid agency as a partner in the collaboration and consequently did not enlist its support in other areas.
- Failure to outreach to non-Head Start Children

- Many programs interpreted the collaborative effort as being limited to providing health services. Thus, programs did not develop relationships with other agencies for the implementation of the effort, i.e., generate contact with Medicaid agencies.

PROBLEMS RELATED TO MEDICAID AGENCIES' PERSPECTIVE

- Confusion/lack of knowledge of local/state Medicaid agencies regarding their role in the Head Start/Collaborative Effort and the extent to which they should interface with the Head Start programs regarding its implementation.
- Failure to disseminate information regarding the collaborative effort within the community.

Lack of Collaboration Between Head Start Programs and Local/State Welfare Agencies Re: EPSDT

In any number of cases, very little collaboration exists between the Head Start/EPSDT demonstration projects and their respective local/state welfare agencies. This is an area which can have considerable impact upon the success or failure of the demonstration effort. Collaboration between the projects and their agencies appears insufficient regarding:

- identification of available EPSDT providers in the community
- outreach efforts made/planned and the community resources available for such
- identification of Medicaid eligible children in the target area; identification of Medicaid eligible children and their families who have already received EPSDT services
- efforts made/planned to raise the consciousness level of community residents, physicians, etc., about EPSDT and the availability of services

- transfer of information and health records on certain children receiving EPSDT services
- coordination of transportation arrangements for children participating in the Head Start/EPSDT Collaborative Effort.

Duplication of services and cost becomes a real possibility in many areas because of the lack of collaboration between local/ state welfare agencies and Head Start programs. A serious concern among the demonstration projects is the possibility of the child being screened/immunized more than once, which can result in duplicate or multiple billing to the state/local Medicaid agency. Further, it creates the unfortunate situation of a provider not being paid for services rendered and may cause alienation and possible resignation from participation.

Provider Attitudes and Practices

Provider attitudes and practices play a significantly high role in the delivery of EPSDT services to Medicaid eligible children. In many instances, they often determine whether or not the child receives EPSDT services.

Some of the prevailing attitudes and practices among providers which affect the implementation of the Head Start/EPSDT Effort are:

- many providers are apprehensive about participating in EPSDT because of their negative experience with Medicaid, e.g., the payment process for services rendered to Medicaid eligibles takes too long, payment for services rendered is often not made or disallowed

- providers are reluctant to assume the administrative burden and cost of completing another form (required in many states) for reimbursement under EPSDT/Medicaid
- Many providers claim to be overloaded already with their regular patients and, therefore, establish quotas as to the number of Medicaid eligible children they will serve; and many times they choose not to serve Medicaid eligibles
- providers have indicated they do not want to be stereotyped as serving Medicaid eligibles for fear of losing their fee-for-services patients
- providers are not committed to EPSDT because the goals and objectives of the program have not been explained to them - many see their involvement in strictly monetary terms.

State Plans

The nature of state EPSDT plans and related provisions influence the capacity of all parties potentially involved in the implementation of the collaborative effort. Some of the issues applicable to state plans are:

- lack of specificity - the format of plans range from general statements to detailed provisions; ambiguity of phrasing impedes implementation of provisions as well as consumer understanding and involvement
- provisions regarding supportive services are frequently obscure in both the provision of and reimbursement for services provided. A prime example is transportation which poses difficulties to many programs
- variation among states in their reimbursement policies for areas of screening can result in:
  - alienation of vendors who apply for reimbursement for services not allowed

  - failure of providers within the community to offer areas of screening for which reimbursement is not permitted, e.g., vision and hearing not reimbursed, psychological screening not reimbursed, nutritional screening not reimbursed, etc

- limitations on vendors restricts the availability of providers and thereby the provision of services for Head Start/EPSDT participants
  - restriction on the awarding of vendor status to community agencies limits the availability of supportive services and the potential for Head Start to become a vender for such services.

Management

The nature of the Head Start/EPSDT Collaborative Effort requires good coordination at all program levels in order for the effort to be successful. Many programs viewed EPSDT as an appendage, rather than an integrated entity of the existing program structure. This resulted in:

- lack of adequate planning regarding the implementation of EPSDT
- lack of collaboration between the social service component of the program and the health services component i.e. certification of Medicaid eligible children in the program, outreach, etc.

Lack of support from the health liaison specialist, and state/local agencies also contributed to the lack of adequate management and planning among many programs regarding the effort.

Outreach

Many Head Start/EPSDT demonstration projects were under the impression that they did not have to outreach for non-Head Start children. Consequently, in many instances outreach was not done or it was confined to siblings of Head Start children. This, of course, impacts very heavily on the collaborative effort, as one of the primary objectives of the effort is to involve as many Medicaid eligible children as possible.

Other problems in outreach are:

- lack of planned outreach strategy, specifically to reach non-Head Start children; failure to use formerly developed strategy for outreach of Head Start children
- lack of adequate staff and resources to administer an effective outreach effort
- lack of cooperation from local/state welfare departments in identifying Medicaid eligibles in the community
- apprehension on the part of some programs about involving non-Head Start Medicaid eligible children because providers often do not have the facilities to accommodate additional children (this includes hospitals, clinics, physicians, etc.)
- many programs are adamant about priority of services to Head Start children and feel very strongly that outreach responsibilities rest with the local/state welfare department.

Follow-up

One of the focal points of the Head Start/EPSDT Collaboration Effort is the extent to which children are receiving follow-up services as a result of a deficiency found in the initial screening. Problems regarding follow-up appear to be more prevalent among non-Head Start children as opposed to Head Start children. Generally, problems fall in the following areas:

- programs failed to develop a system for tracking children (primarily non-Head Start) receiving EPSDT services
- some programs adopt the attitude that it is not their responsibility to follow-up on non-Head Start children, but that of the welfare department
- many programs cited the lack of staff and resources as a deterrent to performing effective follow-up
- programs often experience difficulties in acquiring records/information from providers on children participating in the collaborative effort,e.g.,reluctance to release information because of confidentiality
- mobility of families often makes contact improbable for those children participating in the collaborative effort and in need of follow-up services
- lack of providers and/or transportation (particularly in the rural areas) makes it virtually impossible for many children to receive any necessary follow-up services they may need.

Recordkeeping

Recordkeeping has not been a major issue. That is, it has not been of major consequence regarding services to Medicaid eligible children.

Recordkeeping as it pertains to Head Start children is generally adequate among most of the demonstration projects. There is some concern, however, regarding recordkeeping for non-Head Start children. For the most part, programs do not maintain any records of services to non-Head Start children. Records that are available are usually limited to the initial screening. As previously mentioned, many programs simply have not developed strategies for securing information on the non-Head Start child. In addition, programs still maintain that it is not their responsibility to retain records for non-Head Start children.

Transportation

The inadequacy of transportation arrangements to health service providers in many communities hinders the large-scale involvement of a number of children in the EPSDT collaborative effort. The Medicaid eligible population in many areas has very limited or no transportation of its own. This has serious implications as to the overall success of the collaborative effort. Some of the problems germane to transportation are:

- state/local Medicaid agencies have not been amenable to providing transportation to Medicaid eligible children and their families and/or absorbing the cost
- many states are confused as to what would be the fairest and most equitable approach in drafting a transportation package; many have cited that to provide transportation only for Medicaid EPSDT eligibles would be exclusionary and discriminatory against other individuals who qualify for public assistance
- lack of an aggressive role by local/state welfare agencies in supplementing transportation services that already exist or are being used by the Head Start programs; state/local Medicaid agencies have shown reluctance to negotiate agreements with Head Start programs regarding this issue

- lack of well-planned transportation networks to link children in geographically widespread regions and/or isolated areas to providers of health services
- many programs find that their staff spends an inordinate amount of time transporting children to health providers at the expense of other important program duties and responsibilities
- many state plans lack provisions for transportation or lack provisions for the Head Start program to receive reimbursement for any transportation it provides to those participating in the collaborative effort

Parental Involvement

Within the Head Start/EPSDT effort, the extent to which parents are aware of and involved in health care for their children varies from program to program. The degree of their participation was largely a function of two factors:

- effort by state/local Medicaid agencies and Head Start programs within the community to involve parents in the EPSDT process
- parent's understanding of their role regarding health care for their children.

The principle difficulties pertaining to parental involvement are:

- inadequacy of publicity within the community by state/local agencies to inform parents of the importance of their involvement
- lack of sufficient efforts by Head Start programs to include parents in all phases of health care to the child, e.g., screening, treatment, follow-up
- lack of parental involvement places a heavier burden on programs (which may already be understaffed) to insure that children recieve all requisite health care; programs are also faced with absorbing any additional costs as a result of this effort.

Because some parents totally depend upon Head Start to take the child to a health provider it often precludes any knowledge on the part of the parent(s) as to the type of ongoing care the child may need. Thus, in many instances, the situation prevails where many parents remain crisis-oriented (only taking the child to a doctor when an emergency arises) as opposed to preventive care-oriented, where the child is seen periodically by a doctor.

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REVISED INTERIM REPORT ON EVALUATION OF HEAD START/EPSDT COLLABORATION EFFORT

(APPENDICES)

Prepared for:

OFFICE OF CHILD DEVELOPMENT

March 1976

Prepared by:

Boone, Young & Associates, Inc.
551 Fifth Avenue
New York, New York 10017

APPENDIX A

LIST OF TABLES TO BE COMPLETED FOR FINAL REPORT

The tables identified in the following list and not cited elsewhere in the report will be completed for the Final Report.

Table XVI-A - Indicators of EPSDT Performance: Medical Services-Screening by Aggretated Totals

XVI-A1 - Medical Services: Screening by Selected Projects

XVI-B - Medical Services: Diagnosis and Treatment by Aggregated Totals

XVI-B1 - Medical Services: Diagnosis and Treatment by Selected Projects

XVI-C - Dental Services by Aggretated Totals

XVI-C1 - Dental Services by Selected Projects

XVI-D - Mental Health Services by Aggregated Totals

XVI-D1 - Mental Health Services by Selected Projects

XVI-E - Nutritional Services by Aggregated Totals

XVI-E1 - Nutritional Services by Selected Projects

Table XVII-A - Indicators of EPSDT Performance: Medical Services-Screening by Per Cent for Aggregated Totals

XVII-A1 - Medical Services-Screening by Per Cent for Selected Projects

XVII-B - Dental Services by Per Cent for Aggregated Totals

XVII-B1 - Dental Services by Per Cent for Aggregated Totals

Table XVIII-A - Ranking of Internal Factors Impeding Effectiveness of Head Start/EPSDT Collaborative Effort

XVIII-B - Ranking of External Factors Impeding Effectiveness of Head Start/EPSDT Collaborative Effort

APPENDIX B

PROFILE OF SELECTED STATES

Massachusetts (I)

Montachusetts Opportunity Council

Leominster

- third poorest town in Massachusetts
- project focusing on one rural town within its target area
- lack of providers
- no public transportation
- planned to serve only 50

Worcester Public Schools

Worcester

- largest program in the state
- urban service area
- school system sponsorship
- gaps in preventive health and follow-through in community

New Jersey (II)

Ocean Community Economic Action NOW, Inc.

Toms River

- small program in a rural area

- extreme provider resistance to serving Medicaid patients
- shortage of medical services and isolation from mainstream of medical care
- no public transportation

Paterson Task Force for Community Action

Paterson

- target area in decaying inner city
- providers moving to suburbs, shortage of health professionals
- inacessibility and unacceptability of existing health services
- Spanish-speaking population

United Progress, Inc.

Trenton

- transportation problems
- provider problems
- impoverished target area

Maryland (III)

Baltimore Urban Services

Baltimore

- large urban inner city program
- overcrowded clinics
- inadequate transportation
- established relationship with welfare agencies

Kent-Queen Anne's - Talbot Area

Centerville

- poor transportation
- consumers' lack of information about availability of health services, low utilization; need for extensive outreach
- geographic isolation
- high seasonal unemployment
- poor follow-up and referral
- poor client acceptance for the public assistance programs

This project indicated that it did not have the staff resources to participate in the evaluation and felt that necessary information to complete the evaluation forms was not available.

Mississippi (IV)

Bolivar County Community Action Program

Cleveland

- rural target area covering 929 square miles
- one of the poorest sections of the state, with family size ranging from 1 - 17
- major transportation problems
- 1/2 the identified Medicaid eligible children are not receiving EPSDT services through state resources
- local health department has failed to provide all required services

Tougaloo College

Tougaloo

- target area of 2,693 square miles
- use of a mobile dental medical unit for remote areas
- prior experience in working with Medicaid agencies

Project indicated that it did not receive the amount requested, and could not hire staff to coordinate the EPSDT program. As a result of staff limitations, the director wanted a directive from the Regional Office regarding completion of the evaluative forms, which he never received. The project forwarded no statistical data.

Tennessee (V)

Mid-East Community Action Agency

Kingston

- diversified target area with a cross section of rural, farm, non-farm,and urban areas
- all delegate agencies are school system projects
- extensive follow-up planned

Illinois (VI)

Cook County, Chicago

Chicago

- reluctance of providers to serve Medicaid eligibles
- lack of emergency medical facilities and preventive care

- lack of consumer awareness of available services
- extensive outreach effort planned to bring about maximum utilization of services

St. Clair County

East St. Louis

- decaying inner city
- lack of information regarding available services
- lack of parental motivation to utilize existing services
- transportation problems

Vermillion County Community Action Committee

Danville

- small rural townships with bilingual population
- provider resistance to serving Medicaid patients because of long turnaround time for reimbursement
- consumers lack information about Medicaid program

Ohio (VII)

Cicinnati Area Community Action Committee

Cincinnati

- no public outreach for EPSDT
- no mental health facilities and limited pediatric resources
- state slow in implementing EPSDT
- lack of interagency communication regarding EPSDT

- transportation problems

Montgomery County Community Action Agency

Dayton

- mixed rural-urban target area
- good relationship with providers
- program had limited information regarding EPSDT

Erie - Huron Bi-County Community Action Commission

Sandusky

- unavailability of clinics
- plans to make parents knowledgeable about Medicaid
- large influx of seasonal migrant workers

Boone, Young & Associates anticipated receiving the evaluation forms and attempted to schedule a site visit while in the region; but, the Health Coordinator of the project was not able to see us. They also did not provide any statistical information.

Texas (VIII)

Lubbock County Community Action Board, Inc.

Lubbock

- mixed rural-urban target area
- low estimate of the number to be served
- geographic position

Texas Panhandle Community Action Corporation

Amarillo

- large (26 counties) target area
- home visits to explain the program planned
- eligible families concerned about the stigma of welfare

Texas Migrant Council

Laredo

- one of the few migrant programs in the demonstration
- rural farm target area
- use of an experimental mobile unit
- shortage of providers

Harris County Community Action Agency

Houston

- largest program in the state
- interagency dispute between EPSDT agencies
- lack of transportation
- unavailability and unacceptability of health services

Project was unable to complete the evaluation forms because of limited staff and a large enrollment. (The program, however, did provide copies of the childrens' medical records.)

Missouri (IX)

West Central Missouri Development Corporation

Appleton

- large rural target area
- shortages of health providers
- use of Vista volunteers

Ozarks Area, CAC

Springfield

- physicians' reluctance to participate in EPSDT
- Medicaid reimbursement not in congruence with local fees
- cooperative working arrangements with community agencies

Montana (X)

Billings Yellowstone County CAP

Billings

- 85% of the children are Medicaid eligible, but all are not enrolled
- inadequate formal coordination between service groups
- consumers' lack of information on available services
- transportation problems

Blackfeet Tribe Business Council

Browning

- Indian program
- lack of provider manpower in Indian Health Service
- prior implementation of EPSDT

Fort Peck

Poplar

- Indian program
- rural and economically depressed area
- consumers in need of more information regarding available services

California (XI)

Economic Opportunity Commission of Imperial County

El Centro

- rural agrarian program near Mexican border
- high levels of seasonal unemployment and migrant population
- large numbers of Medicaid eligibles who are not enrolled
- severe provider shortages
- unwillingness of many providers to accept Medicaid clients because of billing procedures

Greater California Education Project

Fresno

- migrant program
- rural communities with high proportion of Mexican-American farm workers
-

Kern County Economic Opportunity Corporation

Bakersfield

- no agency implementing EPSDT in the county

- very conservative medical community
- emphasis on acute care, rather than preventive medicine

This project did not complete the evaluation forms because they had insufficient staff for this purpose. In addition, the project experienced staff turnover, and replacements had not been trained to use the forms.

Oregon (XII)

Lane Community Action Program

Eugene

- program certified vendor of health services
- strong ties with community agencies, including Medicheck

Jackson County Community Development Corporation

Medford

- inadequate transportation and communication networks
- very conservative providers
- some physicians unwilling to take Medicaid patients
- participated in Health Start

APPENDIX C
DATA COLLECTION FORMS

HEAD START/EPSDT
HEALTH CARE INTAKE FORM

Purpose

The Head Start/EPSDT Health Care Intake Form is a duplicate from designed to easily register each child in the Head Start/EPSDT collaboration program at the same time as furnishing background information about the child to both the Health Coordinator and Boone, Young & Associates. The Health Care Intake Form provides data in four areas:

- the child's status with regard to EPSDT/ Medicaid funds
- the child's status with regard to the Head Start program
- the child's status with regard to all health care the child has received during the 12 month period prior to the child's enrollment in this year's Head Start/EPSDT Demonstration Project.
- the child's complete immunization status, that is, all immunizations that are up to data at the time of entrance into the Head Start/EPSDT Demonstration Project.

With this information, the Health Coordinator can assess at a glance the child's status at the beginning of the program and what services are still to be provided, i.e., "where the child has been and where he has to go." In addition, Boone, Young &

Associates will be able to form a data base from which to analyze the incremental effects of the combined Head Start/ EPSDT collaborative effort.

Instructions

This duplicate form is designed for ease of completion: it requires no carbon paper, and the majority of responses can be made by simply inserting the appropriate code numbers of data items into the corresponding boxes which run down the left-hand side of the form. When completing the form, it is important to use STEADY PRESSURE WITH A BALLPOINT PEN. The form will be filled out by the Health Coordinator or other designated Head Start personnel at the time the child is registered in the Head Start/EPSDT program. Boone, Young & Associates recognizes, however, that for many Head Start centers the program year is already underway, if it is not possible to fill out this form at the time the child is actually registered, the intake forms for the EPSDT Collaboration are to be completed within three (3) weeks after receipt of the forms.

There will be one intake form FOR EACH CHILD participating in Head Start and the Head Start/EPSDT Demonstration Effort. This includes:

- Head Start Children who are Medicaid eligible
- Head Start children who are non-Medicaid eligible
- non-Head Start children who are participating in the Head Start/EPSDT effort.

It is anticipated that duplication may exist in the use of this form and the Head Start project's own intake form. However, the Office of Child Development has informed Boone, Young & Associates that this form will be the intake form used by the Head Start/EPSDT Demonstration Projects at the beginning of the next program year (FY 75/76).

Important Steps to Remember

Affixing an I.D. Number

For the purpose of linking records and insuring confidentiality, a Head Start/EPSDT evaluation identification number should be assigned to each form (see Boone, Young & Associates' protocol for ASSIGNMENT OF I.D. NUMBER). The perforated heading at the top of each form allows the Health Coordinator to detach the name of the child from the copy of the form that is sent to Boone, Young & Associates. The Boone, Young & Associates analyst will track each child through the program using only this I.D. number. Further, it should be emphasized that this I.D. number is solely for the purposes of the evaluation of the EPSDT demonstration effort; no effort will be made to tie this information into a central computer or data bank.

Month and Year

- Indicate the month and year for which this form is being completed, e.g., if services were rendered in August of 1974, indicate $\boxed{0}\boxed{8}\boxed{7}\boxed{4}$ in the appropriate box. If services were rendered in November of 1974, indicate:

  $\boxed{1}\boxed{1}\boxed{7}\boxed{4}$ in the proper box.

Intake Form Checklist

- Did you include the I.D. Number?
- Did you insert all appropriate code numbers into the corresponding boxes? Did you apply steady pressure with a BALLPOINT PEN?
- Did you complete the form for each child participating in Head Start and the Head Start/ EPSDT Demonstration Effort?
- Did you check to see that all boxes are filled in and that NO BOXES ARE BLANK?
- Did you check to see that boxes 22 thru 38 have a code of either $\boxed{1}$ or $\boxed{2}$ and NO OTHER NUMBER?

The back copy of the form should be incorporated into the child's medical record at the Head Start center; the TOP copy (with the child's name detached) should be sent to Boone, Young & Associates at monthly intervals.

HEAD START HEALTH CARE INTAKE FORM

085-S-74014A
Expiration 12/31/76
OS-37–74

To be filled out by Health Coordinator:

(Use steady pressure of ballpoint pen)

Name of Child: ____________________

Home Address: (Use pencil and keep current) ____________________
____

IMPORTANT: To be completed for each child participating in Head Start and the Head Start/EPSDT Demonstration Effort; all health related information should be reported for period prior to this year's Head Start/EPSDT Effort.

I.D. NUMBER

1 [1] 2 ☐☐☐☐☐☐☐☐☐☐☐ 12

13 ☐☐☐☐ 16 Date of Birth (Month and Year)

STATUS WITH REGARD TO EPSDT/MEDICAID

(Please place appropriate number in box to left.)

17 ☐
1 Certified as eligible for Medicaid prior to Head Start/EPSDT Program
2 Identified by program as Medicaid eligible but not yet certified
3 Not eligible for Medicaid
4 Medicaid eligibility unknown

STATUS WITH REGARD TO HEAD START

(Please place appropriate number in box to left.)

18 ☐
1 Currently enrolled in Head Start
2 Not enrolled in Head Start

19 ☐ Indicate if the child was previously enrolled in Head Start: [1] Yes [2] No
If yes, indicate year of enrollment: 19____.

20 ☐ If child is not enrolled in Head Start, indicate if child is a sibling of a Head Start child: [1] Yes [2] No
If No, indicate how child was introduced to program:

21 ☐
1 telephone 3 poster 5 relative
2 referral 4 outreach 6 other

PREVIOUS CARE

For each child indicate all health care received during the 12-month period prior to the CHILD'S ENROLLMENT in this year's Head Start/EPSDT Demonstration Project. In addition, record the child's complete immunization status; that is, all immunizations that are UP TO DATE at the time of entrance into the Head Start/EPSDT Program Year. Please indicate by placing the appropriate code in boxes 22-38; e.g.,

[1] Yes (The child has received this service/immunization.)
[2] No (The child has not received this service/immunization.)

MEDICAL

22 ☐ ← ---------------- [1] Yes [2] No SCREENING/PREVENTIVE

TREATMENT

23 ☐ For Acute Condition
24 ☐ For Chronic Condition
25 ☐ Follow-up for Acute or Chronic Condition
26 ☐ Surgical
27 ☐ Corrective Devices Issued (includes eyeglasses)
28 ☐ Prosthetic Devices Issued
29 ☐ Other Treatment

☐ Complete Medical History
☐ Growth Assessment
☐ Vision Testing
☐ Hearing Testing
☐ Speech Screening
☐ Hemoglobin or Hematocrit
☐ Tuberculin
☐ Urinalysis
☐ Sickle Cell Testing
☐ Developmental Assessment

☐ Physical Examination
☐ Lead Poisoning Testing

☐ Immunizations
- ☐ DPT
- ☐ Polio
- ☐ Mumps
- ☐ Measles
- ☐ Rubella
- ☐ Other: (Specify) ____________________

30 ☐ [1] Yes [2] No DIAGNOSTIC TESTING AND EVALUATION BEYOND SCREENING

DENTAL

[1] Yes [2] No

31 ☐☐☐ 33

(31) Initial Assessment/Preventive (Including fluoride applications and space maintainers)

308 A

(32) Ongoing Treatment e.g. Extraction, caries restored, pulp therapy

(33) Treatment for Acute Condition (Services required for relief of pain of infection)

1 Yes 2 No MENTAL HEALTH

34 ☐☐☐ 36 (34) Psychological Testing/Evaluation (35) Referral (36) Counseling

1 Yes 2 No NUTRITIONAL

37 ☐☐ 38 (37) Referred for further assessment (Diagnostic/Evaluation) (38) Treatment for Nutritional Imbalances and Deficiencies (not including lunches or snacks)

39 ☐☐☐☐ 42 Month/Year

Name of Health Coordinator: ______________________
or other designated party (Print or Type)

Code A

HEAD START/EPSDT

HEALTH CARE ENCOUNTER FORM

This triplicate form will provide the health coordinator of each Head Start project with a simplified medical record for each child and will furnish information from the health providers as to the type of services afforded each child. This information will also aid Boone, Young & Associates in determining the nature of the health care given and in analyzing the impact of the Head Start/EPSDT Collaborative Demonstration Program. In addition, the form will be an important source of information to parents and/or guardians--particularly in those cases where they are unable to accompany the child to the health provider--for it furnishes both the parent and the project with a record of the visits and of any necessary follow-up treatment to be provided.

The Health Care Encounter Form will furnish three types of basic information about the health care service provided:

- the type of visit (screening, diagnostic, counseling/referral, or treatment)
- the disposition of the case (including follow-up visits, where indicated)
- the assessed value of the services provided.

Code "E"

The Health Care Encounter Form is to be filled out CUMULATIVELY BY CHILD, BY MONTH.

Thus, if a child receives a vision test, hearing test, growth assessment and dental examination, all in the same month, only one Encounter Form should be filled out for this child for the month. Conversely, if the identical tests are spread out over a period of four months, four Encounter Forms would be needed for this child. However:

The very first Encounter Form for each child should be CUMULATIVE, STARTING WITH THE BEGINNING OF THE HEAD START/ EPSDT DEMONSTRATION YEAR.

Thus, if your Head Start/EPSDT Demonstration effort began in July and you receive the forms in December, the first Encounter Form would take in this July-December period. For example, the first Encounter Form will record all the medical care that the child has received from his/her intake into the EPSDT Demonstration Effort through December 31, 1974. The second Encounter Form will record all the health care he/she has received for the month of January, 1975. In a case where absolutely no care has been given the child, no form will be filled out for that month.

The first Encounter Form collects information about services rendered to individual children from the beginning of your Head Start/EPSDT year to the date on which you receive these forms. This is being done to simplify the process of data retrieval and to consolidate much of the information, since it is Boone, Young & Associates' understanding that the program year is already well under way in many Head Start centers.

Of the three parts of this triplicate form, one copy will be incorporated into the child's medical record at the Head Start center, one copy will be given to the parent or guardian, and the TOP copy will be sent to Boone, Young & Associates. To insure confidentiality, a perforated heading has been added to the form and the health coordinator should detach the name of the child from the rest of the form before sending the information on to Boone, Young & Associates. The Boone, Young & Associates analyst will use only identification numbers in tracking individual children through the program.

Instructions

The Head Start/EPSDT Health Care Encounter Form is a triplicate form (requiring no carbon paper) designed for easy inspection and for ease of completion. Responses to a multitude of data items involve simply inserting the code numbers of those items into the corresponding boxes which run down the left-hand side of the form. When completing the form, it is important to use STEADY PRESSURE OF A BALLPOINT PEN.

The health coordinator or other designated Head Start personnel will complete the form, starting with the heading:

- Enter the name of the child
- Enter the child's I.D. number for the purposes of the Boone, Young & Associates evaluation of Head Start/ EPSDT (see Assignment of I.D. number)
- Enter child's sex and the month and year of birth. In recording the month and year of birth, LEAVE NO BLANK BOXES, i.e., if a child was born in February, 1970, it would be recorded |0|2|7|0|, for a child born in November, 1970 it would read |1|1|7|0|
- Indicate if for this month any transportation to take the child to the site of the health care encounter was provided or arranged for by Head Start
- Indicate the month and year for which this form is being completed in the box marked Date of Encounter

The remaining part of the form is to be completed by the health provider or the health coordinator or any person designated by the health coordinator with this responsibility. If the form is to be completed by the health provider, care must be taken by the physician, nurse or other representative of the provider to fill out the form with the following information:

- Type of Visit:

  whether services were provided in the area of medical care, dental care, mental health or nutrition

- Purpose of the Encounter:

  the provider will indicate the nature of the care given by inserting the code numbers for the categories of screening, diagnosis and treatment into the corresponding boxes on the left-hand side of the form.

- Disposition of the Case:

  whether the problem was able to be resolved or it the case had to be referred to another provider; where any follow-up treatment is needed, the health provider will so indicate.

- Assessed Value of Services;

  this is the amount that the physician or clinic would normally charge a Head Start patient for the service.

- Method of Payment

If the health provider is not asked to fill in this information, then the health coordinator or person he/she so designates must assume responsibility for ascertaining what services were rendered to the child.

The Encounter Form is to be completed by indicating the method of payment(s) for the encounter(s) i.e., whether paid for in cash or billed to Head Start, Medicaid, another third party (insurance), or the child's parents) and by filling in the total assessed value of services provided.

The back copy of the form should be given to the parent/guardian or accompanying adult with an appointment card (if follow-up treatment is indicated). The rest of the form should be returned to the health coordinator, who will keep the middle copy for her/his own files and send the TOP copy to Boone, Young & Associates after removing the perforated top portion.

Important Steps to Remember

Affixing an I.D. Number

For the purpose of linking records and insuring confidentiality, a Head Start/EPSDT evaluation identification number should be assigned to each child (see Boone, Young & Associates' protocol for ASSIGNMENT OF I.D. NUMBER). The perforated heading at the top of each form allows the Health Coordinator to detach the name of the child from the copy of the form that is sent to Boone, Young & Associates. The Boone, Young & Associates analyst will track each child through the program using only this I.D. number. Further, it should be emphasized that this I.D. number is solely for the purposes of the evaluation of the EPSDT demonstration effort; no attempt will be made to feed this information into a central computer or data bank.

The Medical Screening Package

Boone, Young & Associates recognizes that the complete screening package offered by some programs does not include certain items listed on the Encounter Form (e.g., sickle cell testing, blood lead, intestinal parasites screening). When all items offered in the medical screening package AS DEFINED BY YOUR HEALTH ADVISORY COMMITTEE have been provided to the child, mark the code next to "SCREENING CONSIDERED COMPLETE."

Assessed Value of Services

For the very first set of encounter forms only, indicate the assessed value of any health services provided to the child UNDER THE HEAD START/EPSDT PROGRAM TO DATE; for all subsequent encounter forms, indicate the assessed value for only those services provided during the month for which the form is being completed. This assessed value is the amount the program/provider (physician or clinic) would charge Head Start for this service.

Assessed value in this instance does not apply to the reimbursement amount EPSDT Medicaid will pay the health provider for services rendered to the child. It also does not apply to the fee a physician would charge in the private sector.

Rather, assessed value should reflect the value the health provider (physician or clinic) would place on the specific services rendered to the child participating in Head Start or the Head Start/EPSDT Demonstration Effort.

For example, a physician may charge $10.00 for a vision testing in the private sector; EPSDT Medicaid may only reimburse $6.00 for vision testing; and a health provider may assess the value of vision testing to the Head Start child or the child participating in the Head Start/EPSDT Demonstration Effort at $7.00. Of course, the health provider cannot charge the party (Head Start, parent, etc.) in excess of the Medicaid rate of reimbursement, which in this case is $6.00. Despite this fact, it is the value a provider places on services to the child participating in Head Start that should be reflected as the assessed value on the Encounter Form. For purposes of this example, the assessed for a vision testing would be reported at $7.00.

Encounter Form Checklist

- Did you include the child's I.D. Number? (This is the same number you assigned to the child on the Intake Form.)
- Did the person filling out the form (i.e., provider, nurse, or other person designated by the health coordinator) insert all code numbers that pertain to this child into the corresponding boxes on the left side of the form? Did he/she apply STEADY PRESSURE WITH A BALLPOINT PEN?
- Has the assessed value of services been indicated?
- Has the method of payment been recorded (whether services were billed to Head Start, Medicaid or another party, such as parent or insurance).
- If this is the child's first encounter form, did you include the assessed value for any services that may have been rendered to the child since the beginning of the Head Start/EPSDT program year?
- Has the name of the health coordinator or other designated person been indicated?
- Has the back copy of the form been given to the parent/guardian?
- Has the middle copy been incorporated into the child's medical record at the Head Start Center?
- Has the TOP copy (with the child's name detached) been prepared for transmittal to Boone, Young & Associates (at monthly intervals)?
- Have you checked to see that all boxes have been filled in and that NO BOXES ARE BLANK?

085-S-74014B
Expiration 12/31/76
OS-37-74

HEAD START HEALTH CARE ENCOUNTER FORM

IMPORTANT: To be completed for each child in Head Start and the Head Start/EPSDT Demonstration Effort.

Patient Name: ____

I.D. NUMBER

1 2 2 ☐☐☐☐☐☐☐☐☐☐☐ 12 (see instructions)

13 ☐ Sex — 1 Male 2 Female

14 ☐☐☐☐ 17 Date of Birth (month and year)

18 ☐☐☐☐ 21 Date of Encounter (month and year)

22 ☐ Indicate if transportation provided or arranged by Head Start: 1 Yes 2 No

To be filled in by Health Provider or Health Coordinator

Please indicate the type of service provided by placing the appropriate code in the box to the left; e.g.

1 Yes (The child has received this service)
2 No (The child has not received this service)

MEDICAL

23 ☐ ------------------------------------- SCREENING/PREVENTIVE 1 Yes 2 No

TREATMENT (24-30) 1 Yes 2 No

24 ☐ For Acute Condition
25 ☐ For Chronic Condition
26 ☐ Follow-up for Acute or Chronic Condition
27 ☐ Surgical
28 ☐ Corrective Devices Issued (includes eyeglasses)
29 ☐ Prosthetic Devices Issued
30 ☐ Other Treatment

☐ Complete Medical History
☐ Growth Assessment
☐ Vision Testing
☐ Hearing Testing
☐ Speech Screening
☐ Hemoglobin or Hematocrit
☐ Tuberculin
☐ Urinalysis
☐ Sickle Cell Testing
☐ Developmental Assessment

☐ Physical Examination
☐ Lead Poisoning Testing

☐ Immunizations
- ☐ DPT
- ☐ Polio
- ☐ Mumps
- ☐ Measles
- ☐ Rubella
- ☐ Other: (Specify) ____________________

31 ☐☐ 32 (31) SCREENING CONSIDERED COMPLETE 1 Yes 2 No

(32) DIAGNOSTIC TESTING AND EVALUATION BEYOND SCREENING 1 Yes 2 No

DISPOSITION OF CASE: (Indicate code that applies in boxes to left — 1 Yes 2 No)

33 ☐☐☐ 35 (33) Completed (34) Referred (35) Follow-up Required

ASSESSED VALUE OF SERVICES: (Indicate value of each service on line to right.)

In boxes to left, indicate

36 ☐☐☐☐ 39 TOTAL VALUE of all medical services

Screening $ ____________
Diagnosis $ ____________
Treatment $ ____________
TOTAL VALUE $ ____________

METHOD OF PAYMENT:

(Indicate in applicable box the code 1 Yes 2 No)

40 ☐☐☐ 42 (40) Head Start (41) Medicaid (42) Other (specify) ____________________

DENTAL

43 ☐ Initial Assessment/Preventive (including fluoride applications & space maintainers)
44 ☐ Ongoing Treatment (Caries restored, pulp therapy, extraction, etc.)
45 ☐ Treatment for Acute Condition (Services required for relief of pain or infection)

DISPOSITION OF CASE: (Indicate code that applies in boxes to left — 1 Yes 2 No)

46 ☐☐☐ 48 (46) Completed (47) Referred (48) Follow-up Required

ASSESSED VALUE OF SERVICES: (Indicate value of each service on line to right.)

In boxes to left, indicate

49 ☐☐☐☐ 52 TOTAL VALUE of all dental services

Initial Assessment $ ____________
Ongoing Treatment $ ____________
Treatment/Acute $ ____________
TOTAL VALUE $ ____________

METHOD OF PAYMENT:

(Indicate in applicable box the code 1 Yes 2 No)

53 ☐☐☐ 55 (53) Head Start (54) Medicaid (55) Other (specify) ____________________

MENTAL HEALTH

56 ☐ Psychological Testing/Evaluation
57 ☐ Referral
58 ☐ Counseling

DISPOSITION OF CASE: (Indicate code that applies in boxes to left — 1 Yes 2 No)

59 ☐☐☐ 61 (59) Completed (60) Referred (61) Follow-up Required

ASSESSED VALUE OF SERVICES: (Indicate value of each service on line to right.)

In boxes to left, indicate

62 ☐☐☐☐ 65 TOTAL VALUE of all mental health services

318

Psychological Testing $ ____________
Referral $ ____________

Counseling $ ____________

TOTAL VALUE $ ____________

METHOD OF PAYMENT:

(Indicate in applicable box the code 1 Yes 2 No)

66 ☐☐☐ 68 (66) Head Start (67) Medicaid (42) Other (specify) ____________

NUTRITION

69 ☐ Referred for Further Assessment/Diagnostic Evaluation

70 ☐ Treatment for nutritional imbalances & deficiencies (not including meals & snacks)

DISPOSITION OF CASE: (Indicate code that applies in boxes to left — 1 yes 2 No)

71 ☐☐☐ 73 (71) Completed (72) Referred (73) Follow-up Required

ASSESSED VALUE OF SERVICES: (Indicate value of each service on line to right.)

In boxes to left, indicate TOTAL VALUE of all nutrition services

74 ☐☐☐☐ 77

Further Assessment $ ____________

Diagnosis $ ____________

Treatment $ ____________

TOTAL VALUE $ ____________

METHOD OF PAYMENT:

(Indicate in applicable box the code 1 Yes 2 No)

78 ☐☐☐ 80 (78) Head Start (79) Medicaid (80) Other (specify) ____________

NAME OF PROVIDER REPRESENTATIVE: ____________ DATE ____________

NAME OF HEALTH COORDINATOR OR OTHER DESIGNATED PARTY: ____________

Code B

HEAD START/EPSDT

HEALTH CARE COMPOSITE VISIT FORM

This duplicate form is designed to benefit the Head Start projects and the evaluators of the Head Start/EPSDT demonstration effort. It will provide the health coordinator with a simplified record of services delivered under the EPSDT mandate, serve as an aid in filling out HPAR's, and furnish information as to the breadth of services afforded to the children. This information will in turn aid Boone, Young & Associates in determining the nature of the health care given, and in analyzing the impact of the Head Start/EPSDT Collaborative Demonstration Program. This information will be collected on two separate forms. One to be completed only for Head Start children, and one for all NON-HEAD START children.

The Health Care Composite Visit Form will furnish two types of basic information about the Head Start/EPSDT health component:

- the total number of visits by type (screening, diagnostic, counseling/referral, or treatment)
- the disposition of cases (the number of referrals and follow-ups)

9

Code "F"

The health care composite visit form is to be filled out CUMULATIVELY BY PROJECT, BY MONTH FOR HEAD START CHILDREN ON ONE FORM, AND NON-HEAD START CHILDREN ON THE OTHER.

For example, if a certain project has given its Head Start population 150 hearing tests,10 vision test and 2000 growth assessments, in the month of February these numbers will be recorded in the boxes next to these items.

/2/0/0/0/	Growth Assessment
/0/0/1/0/	Vision Testing
/0/1/5/0/	Hearing Testing

Since hearing, vision and growth assessment all fall under the general heading of Medical Screening, the total number of medical screenings recorded in boxes (13-16) would be 2160-/2/1/6/0/ (hearing + vision + growth assessment). Please follow the same procedure on the form marked (NON-HEAD START CHILDREN) for all children not currently enrolled in Head Start who received services during that month.

The very first Composite Visit Form for each project will be CUMULATIVE, STARTING WITH THE BEGINNING OF YOUR PROGRAM YEAR USING THE INDICATED FORM FOR EACH GROUP HEAD START AND NON-HEAD START

The first Composite Visit Form collects information about the amount and kinds of services rendered to the two groups of children, from the beginning of your program year to the date on which you receive these forms. Thus if your program year began in July and you receive the forms in December, the first Composite Visit Form will take in this July-December period; all subsequent Composite Visit Forms will be completed monthly. This is being done so as to simplify the process of data retrieval and to consolidate much of the information, since it is Boone, Young & Associates' understanding that the program year is already well under way in many Head Start centers.

Instructions

The Head Start/EPSDT Health Care Composite Visit Form is a duplicate form (requiring no carbon paper) designed for easy inspection and for ease of completion. Responses to a multitude of data items involve simply filling in the total number of each of the various types of screenings, etc. with steady and firm pressure of a ballpoint pen.

The health coordinator or other responsible Head Start personnel will complete the form, starting with the heading:

- enter the project I.D. Number (see Boone, Young & Associates' protocol for ASSIGNMENT OF I.D. NUMBER)
- enter the name and address of project
- indicate month and year for which this form is being completed.
- use the separate forms marked (FOR HEAD START CHILDREN) and (FOR NON-HEAD START CHILDREN) for the respective groups.

Then, in the space to the left of each category, the health coordinator will indicate the number of children in each group who have received various types of services during the month for which the Composite Visit Form is being completed.

Important Steps to Remember

Affixing a Project I.D. Number

For the purposes of linking records and insuring confidentiality, a Head Start/EPSDT evaluation identification number has been assigned to each grantee and delegate agency (see Boone, Young & Associates protocol for ASSIGNMENT OF I.D. NUMBER). We must emphasize that this I.D. Number is solely for the purposes of the evaluation of the EPSDT demonstration effort; no attempt will be made to tie this information into a central computer or data bank.

The Medical Screening Package

Boone, Young & Associates recognizes that the complete screening package offered by some programs does not include certain items listed on our Composite Visit Form (e.g., sickle cell testing, blood lead, intestinal parasites screening, If all items offered in the medical screening package AS DEFINED BY YOUR HEALTH ADVISORY COMMITTEE have already been provided to some or all of the children, indicate the number of complete screenings given in the appropriate box.

Composite Visit Form Checklist

- Did you use the proper forms for Head Start and non-Head Start children?
- Did you include the project I.D. Number on both forms?
- Have the total number of screenings, treatments, and follow-ups been indicated next to the appropriate items for each group?
- Did you complete the (for Head Start Children) form for ALL children enrolled in Head Start who received services during the month?
- Did you complete the (for Non-Head Start Children) form for all children not enrolled in Head Start, but participating in the collaboration effort who received services during the month.

The back copy of the composite visit form should be kept by the Head Start center; the TOP copy should be sent to Boone, Young & Associates at monthly intervals.

HEAD START HEALTH CARE COMPOSITE VISIT FORM
(For Non-Head Start Children)

085-S-74014C
Expiration – 12/31/76
OS-37-74

To be filled in by Health Coordinator at end of each month.
Record cumulative health care services (use steady pressure of ballpoint pen).

IMPORTANT: To be completed for health care services provided to all children not currently enrolled in Head Start who are participating in the Head Start /EPSDT Demonstration Effort.

I.D. NUMBER
1 5 2 8

Name of Project ____________________

Address ____________________

9 12 Date of Health Care Composite Visit Form (month and year)

In the boxes to the left of each category of SCREENING/PREVENTIVE, DIAGNOSIS, or TREATMENT, indicate the total number of children in your Head Start/EPSDT program who received services during the past month.

MEDICAL

13 16 – – – – – – – – – – SCREENING/PREVENTIVE (13-16)

TREATMENT (17-40)
17 20 For Acute Condition
21 24 For Chronic Condition
25 28 Follow-up for Acute or Chronic Condition
29 31 Surgical
32 35 Corrective Devices Issued (includes eyeglasses)
36 37 Prosthetic Devices Issued
38 40 Other Treatment

Complete Medical History
Growth Assessment
Vision Testing
Hearing Testing
Speech Screening
Hemoglobin or Hematocrit
Tuberculin
Urinalysis
Sickle Cell Testing

Physical Examination
Developmental Assessment
Lead Poisoning Testing
Immunizations:
DPT
Polio
Mumps
Measles
Rubella
Other:
(Specify) ____________________

41 44 (41-41) SCREENING CONSIDERED COMPLETE
45 48 (45-48) DIAGNOSTIC TESTING AND EVALUATION BEYOND SCREENING

DISPOSITION OF CASES:
49 52 Number Completed
53 56 Number Referred
57 60 Number Requiring Follow-up

NUTRITION

61 64 Referred for Further Assessment/Diagnostic Evaluation
65 68 Treatment for nutritional imbalances & deficiencies (not including meals & snacks)

DISPOSITION OF CASES:
69 72 Number Completed
73 76 Number Referred
77 80 Number Requiring Follow-up

I.D. NUMBER
1 6 2 8 Indicate I.D. NUMBER as above

9 12 Date of Health Care Composite Visit Form (month and year)

DENTAL

13 16 Initial Assessment/Preventive (including fluoride applications & space maintainers)
17 20 Ongoing Treatment (Caries restored, pulp therapy, extraction, etc.
21 24 Treatment for Acute Condition (Services required for relief of pain or infection)

324A

DISPOSITION OF CASES:

25	☐☐☐☐	28	Number Completed
29	☐☐☐☐	32	Number Referred
33	☐☐☐☐	36	Number Requiring Follow-up

MENTAL HEALTH

37	☐☐☐☐	40	Psychological Testing/Evaluation
41	☐☐☐☐	44	Referral
45	☐☐☐☐	48	Counseling

DISPOSITION OF CASES:

49	☐☐☐☐	52	Number Completed
53	☐☐☐☐	56	Number Referred
57	☐☐☐☐	60	Number Requiring Follow-up

Name of Health Coordinator or
Other Designated Party ______________________________
(Print or Type)

STAFF PROFILE FORM

The Staff Profile Form will be used to review the staffing patterns of the EPSDT demonstration projects and to assess the effectiveness of the respective staffing patterns in making EPSDT services available to Medicaid eligible children and their families. This form will also provide an important source of information in identifying problems related to staffing patterns, e.g. vacancies or shortages. Moreover, the information collected from this form will be correlated with other evaluative data for the purpose of developing replicable approaches for achieving local collaboration in the delivery of EPSDT services.

The Staff Profile Form is designed to gain requisite background information on Head Start staff and volunteers participating in the Head Start/EPSDT collaboration effort. More specifically, the form solicits information regarding the individual's position/title within the project, the applicable duties and responsibilities connected with this position, the educational background of the individual, residency of the staff member relative to the target area, and other background data as requested in the form.

Instructions

The Staff Profile Form should be completed only by those individuals participating in the Head Start/EPSDT collaboration

Code "H"

effort. This is to include Head Start salaried and non-salaried staff and volunteers of the program. Any Head Start employee or volunteer whose responsibilities are not attributable to Head Start/EPSDT services should not complete this form.

With respect to Head Start/EPSDT volunteers, if one does not volunteer on a regular basis or has minimal input into the Head Start/EPSDT effort, it is not expected that this individual complete the form. On the other hand, if someone is a regular volunteer, making a sizable contribution the the collaboration effort, it is most certainly expected that this person complete the form.

The Staff Profile Form is to be completed only once during the program year. The form should be completed as soon as it arrives at the program. Responses to all information requested should be made in ink. Each Head Start staff member or volunteer may complete his/her own Staff Profile Form or it may be completed by the health coordinator on behalf of each staff member or volunteer participating in the EPSDT collaborative effort. In any event, responsibility rests with the health coordinator to see that all Staff Profile Forms are completed accurately and forwarded to Boone, Young & Associates for processing.

Staff Profile Form Checklist

- Has the project I.D. Number been indicated on the form?
- Was this form completed by only those individuals participating in the Head Start/EPSDT collaboration effort (including Head Start salaried and non-salaried staff members and volunteers)?

085-S-74014 F
Expiration 12/31/76
OS-37-74

STAFF PROFILE FORM
HEAD START/EPSDT

I.D. NUMBER: ____________________

Program Name and Address:

____

____

____

Indicate Position/Title with the Program and the Number of Years in this Position:

Position/Title ____________________ No. of Years ____________

List the Duties and Responsibilities of this Position:

____

____

____

____

Indicate Whether Employment with the Project is:

____ Full-Time
____ Part-Time
____ Volunteer
____ Other

List Previous Positions/Titles, if any, with the Head Start/EPSDT Program and the Number of Years in the Respective Position (if not applicable, kindly check ( ) "Not Applicable").

Position/Title ____________________ No. of Years ____________

Position/Title ____________________ No. of Years ____________

Position/Title ____________________ No. of Years ____________

☐ Not Applicable

Indicate Duties and Responsibilities of Previous Positions in the Order Listed Above. (If not applicable, kindly check ( ) "Not Applicable.")

____

____

____

____

☐ Not Applicable

STAFF PROFILE FORM (Cont'd.)

Indicate Highest Level of Educational Achievement:

	1	2	3	4	
High School	☐	☐	☐	☐	
College	☐	☐	☐	☐	Degree Obtained ______________

Graduate School ☐ Degree Obtained ______________________

Post Graduate School ☐ Degree Obtained ______________________

*Other Professional Training ______________________________

**Head Start Related Training ______________________________

List any Prior Positions Held Outside of the Head Start/EPSDT Program Over the Past Five Years and the Number of Years in the Respective Position.

Position __________________________ No. of Years _______

Position __________________________ No. of Years _______

Position __________________________ No. of Years _______

Summarize the Duties and Responsibilities of the Above Positions.

____

____

____

____

____

*Licensed Practical Nurse, Registered Nurse, etc.

**Special Courses, Workshops, Seminars, etc.

TIME UTILIZATION FORM

The primary function of the Time Utilization Form is to assess the distribution of Head Start/EPSDT staff time to the following categories:

- Direct Labor
- Supportive Labor
- Administrative Labor.

This information will be useful in determining how the allocation of staff time affects the program's ability to reach and provide EPSDT services to Medicaid eligible children.

It should be clearly understood that it is not the intent of this form to monitor the individual performance of those involved in the Head/Start/EPSDT program. Rather, the form is designed to collect requisite cost data to be analyzed in conjunction with other evaluative information for the purpose of developing replicable approaches for achieving local collaboration in the delivery of EPSDT services. It is anticipated that responses to the form will vary from program to program; there are no right or wrong responses.

Requisite to completing the form it is essential that one have a basic understanding of what is meant by direct labor, supportive labor and administrative labor. Thus we have provided the following information.

Direct Labor

Direct labor involves that time spent by staff personnel which is directly ascribable to medical units of service rendered to the Head Start/EPSDT child and his/her family. This includes medical units of service applicable to:

- Screening
- Diagnosis
- Treatment

Time involved in direct counseling and laboratory services for children and their families should also be included.

Supportive Labor

Supportive labor involves that time devoted by staff persons to insure quality and ongoing services to the child and other family members:

- time engaged in improving the performance of staff personnel involved in direct services to the child/family, e.g. training of counselors and health educators, in skills necessary for better counseling and health education
- time allocated to the outreach effort for purposes of soliciting more children and their families to use Head Start/EPSDT services
- time used in transporting the child to and from the clinic site; time involved in babysitting to allow the parent the choice of seeing that the child receives available EPSDT services
- time spent making referrals to providers and other community resources involved in the Head Start/EPSDT effort
- any other time deemed justifiable by the project as a supportive service.

Administrative Labor

Administrative labor is that time connected with the administrative functions of the program. This refers to:

- time required for the preparation of monthly/quarterly reports or any such reports as may be required
- time applicable to negotiating Medicaid agreements with local, state agencies; negotiating agreements with health providers and other community resources for delivery of health services to children and their families
- time involved in conference workshops applicable to the affairs of the project, e.g., financial management workshops, third-party reimbursement forums, etc.
- any other time spent on tasks administrative in nature.

While each of the above categories describes several services to which time is attributable, it should be clearly understood that the allocation of time to each of these categories should be a *composite* of the total time spent in all the services representative of the respective category. For example:

Administrative Labor

Negotiation
Workshops
Reports

} Total time spent in all three areas should be allocated to the administrative category

Instructions (General)

The Time Utilization Form should be completed by *only* those individuals involved in the Head Start/EPSDT demonstration effort. This is to include both salaried and non-salaried staff members and volunteers.

With respect to volunteers, if one volunteers only infrequently or has minimal input into the Head Start/EPSDT effort, it *is not* expected that this individual complete the form. On the other hand, if one is a regular volunteer, making a sizable contribution to the Head Start/EPSDT effort, it is most certainly expected that this person complete the form.

Each individual involved in the Head Start/EPSDT effort should complete his/her own Time Utilization Form, including volunteers. The health coordinator will be responsible for seeing that all Time Utilization Forms are completed and that the information requested is accurately reported.

It should further be stressed that the Time Utilization Form is to be completed for *only the time involved in Head Start/EPSDT services*. This is *not* to include time for any other Head Start functions performed during the course of the day or period. An individual could conceivably spend a portion of his/her time in various Head Start functions; but it is only the *universe or total* of that time spent in Head Start/EPSDT services that is applicable to this form.

The Time Utilization Form is to be completed four times (quarterly) during the program year for the following periods:

July 1, 1974-September 30, 1974
October 1, 1974-December 31, 1974

Code "K"

January 1, 1975-March 31, 1975
April 1, 1975-June 30, 1975.

At the end of each period (September 30, December 31, March 31, and June 30) each individual participating in the Head Start/EPSDT effort should estimate for each labor category (direct, supportive, and administrative in terms of percentage how his/her time, with respect to Head Start/EPSDT, was spent during each three-month period. Because the *universe or total* of only that time spent in Head Start/EPSDT services is the basis for allocation not the total time spent in all Head Start areas total percentage distribution to the respective labor category should always equal 100%.

It is anticipated that most pilot programs will be well into their program year by the time these forms are received. Consequently, it will be necessary to retrieve data retroactive to the inception of the program year and report the same in accordance with the quarterly reporting periods. Boone, Young & Associates will call upon the health coordinator for this information within a period not to exceed ten days of each quarter's end.

Instructions (Specific)

In the upper right-hand corner of the form itself, enter the reporting period, e.g., July 1-September 30.

The Project I.D. number and name and address of the Head Start/EPSDT pilot project should be entered at the top of the form, followed by position/title of the staff member or volunteer completing the form.

The "Compensation ($) This Period" should be inserted next. "Compensation This Period" pertains to that portion of the individual's earnings, over a three-month period, which are attributable to his/her involvement in Head Start/EPSDT activities only. The amount of compensation reflected should represent the actual earnings of the individual for the three-month period involved.

The fiscal officer will be responsible for assessing the "Compensation this period." Assessing the "Compensation This Period" should be a relatively simple task, as it only requires that one know his/her gross earnings for *all* Head Start labor time during the three-month period, and that one know or approximate the *percentage* of total Head Start labor time for the same period *attributable to EPSDT services only*.

e.g. gross earnings for period July 1 through September 30 for all Head Start labor time = $4,000

estimated percentage (%) of total Head Start labor time for period July 1 through September 30 spent in Head Start/EPSDT services *only* = 20%:

20% of $4,000 is 800

($4,000 X 20% = 800)

therefore,

$800 = Compensation This Period.

The allocation of one's total compensation to the three labor categories (on the Time Utilization Form) will ultimately be reflected in the expenditure form in the same distribution. For example, if the aggregate of the four Time Utilization Forms shows the allocation of one's total compensation as follows:

Direct Labor	= $4,000.00
Supportive Labor	= $3,000.00
Administrative Labor	= $1,000.00

The above distribution (as a part of all labor dollar allocation) will be so reflected in the expenditure form, under the category of salaries and wages for direct costs, supportive costs, and administrative costs respectively.

In Column #1 enter the percentage of time spent in Head Start/EPSDT *direct* services as it relates to the universe or total time in all Head Start/EPSDT services.

In Column #2 estimate for the three-month period the percentage of time spent in Head Start/EPSDT *supportive* services as it relates to the universe or total time spent in all Head Start/EPSDT services.

In Column #3 estimate for the three-month period the percentage of time spent in administrative services as it relates to the universe or total time spent in all Head Start/EPSDT services.

Do not make entries in Column #4, "Total," or the columns (reading horizontally) headed "Allocation of Compensation This Period."

It must be stressed again that for the purposes of this form the percentage allocation of one's time to the aforementioned labor categories should reflect only the amount of time applicable to *Head Start/EPSDT services*. Thus, the universe or the total time attributable to EPSDT services is the only labor time to be reflected in the form.

It should also be remembered that the percentage distribution to labor categories should always equal 100%.

Upon completion of each Time Utilization Form it should be returned to the health coordinator and readied for transmittal to Boone, Young & Associates.

Time Utilization Checklist

- Did you record the Project I.D. Number?
- Did the Fiscal Officer indicate the "Compensation This Period"?
- Did you record the correct "Reporting Period"?
- Does the distribution of percentages to the labor categories equal 100%?
- Did you leave Column #4 and the column applicable to the "Allocation of Compensation This Period? blank, as instructed?

085-S-74014 G
Expiration 12/31/76
OS-37-74

TIME UTILIZATION FORM

Reporting Period ____________________

Project I.D. Number ____________________

Program Name ____________________

Address ____________________

Position/Title of Staff
Member/Volunteer
Completing This Report ____________________

*Compensation ($) This Period ____________________

For Head Start/EPSDT Time Only

NOTE: Fill in Columns 1, 2, and 3 for Percentage of Time Spent in Labor Categories. DO NOT Total Column 4. DO NOT make entries in any of the columns related to Allocation of Compensation This Period.

(Tear Off Here)

LABOR CATEGORIES

	(1) Direct	(2) Supportive	(3) Admin.	(4) Total
Percentage of Time Spent in Labor Categories	%	%	%	%
Allocation of Compensation ($) This Period	$	$	$	$

*To be obtained from Fiscal Officer.

INCOME SOURCES FORM

The primary purpose of the Income Sources is to ascertain the extent to which the Head Start/EPSDT program is making use of all available resources from the federal level to the private citizen in meeting program goals and objectives.

The seven revenue categories in the Income Sources Form should enable the analyst to differentiate between earned and unearned income, and further trace support of program activities to voluntary contributions, appropriations and in-kind support. The income data collected will be analyzed and correlated with other pertinent data in order to assess the effectiveness of the collaborative effort and to develop replicable approaches for achieving local collaboration in the delivery of EPSDT.

Instructions

It is important to note that the Income Sources Form should be completed for only that income attributable or accruing to Head Start as a result of the Head Start/EPSDT program.

It should be completed by the health coordinator in cooperation with the fiscal officer of the Head Start project.

This form is to be completed only once during the program year--at the end of the Head Start/EPSDT fiscal period (June 30, 1975). Boone, Young & Associates will, however, request a select number of projects (30) to periodically forward a copy of their monthly, year-to-date income statements. This procedure will provide a means for verifying information reported. The 30 projects selected will be notified.

While the form will be completed only once during the program year, it is important that all income data reported be reflective of the entire program year. The reporting period should reflect activity beginning July 1, 1974 to June 30, 1975.

The health coordinator will be responsible for seeing that the Income Sources Form is completed and forwarded to Boone, Young & Associates.

In completing the Income Sources Form care should be taken to record revenues on an accrual basis. That is, revenues should be recorded when they are "earned" and not simply on the basis of when cash is actually received in hand. For example, billings to the federal government or the local Medicaid agency for services rendered should normally be recorded as income at the time of billing.

In addition, where actual revenue figures cannot be provided by the accountant and/or bookkeeper or responsible party, estimates should be applied. In this instance, it should be so indicated by placing EST. in parentheses (EST.) next to the figure(s). In all cases where the information is not applicable, "0" should be placed in the amount column.

The following steps should be taken in filling out the form.

At the top of the form, indicate the Project I.D. Number and the name of the Head Start/EPSDT project.

Next, the reporting period representative of the information to be recorded should be indicated. (This should reflect the period beginning July 1, 1974 and ending June 30, 1975.)

The name of the person completing the form should be indicated.

ALL INCOME REPORTED SHOULD REFLECT AN ENTIRE YEAR's ACTIVITY.

I. Revenue from Governmental Sources: enter the amount of monies received/earned through federal, state and local grants in connection with the Head Start/EPSDT collaborative effort.

II. Third Party Payors: enter the amount of monies received/earned through third-party payors such as Medicaid and other such purchase of service agreements that have been reached.

III. Direct Patient Payments: enter the amount of dollars received/earned through direct services to children and their families.

IV. Cash Contributions: enter unearned income from voluntary contributions, e.g. foundations, endowment, and private sources.

V. Donated Services and Materials: enter the assessed value of in-kind support from non-cash donations, e.g. volunteer personnel services, materials (educational), and other contributions of a non-cash nature incremental to program services. In assessing the value of non-cash contributions it is important that the cost as applicable in the community apply, e.g.

volunteers - the hourly rate already being paid to employees in like positions or the hourly rate on the open market in the community for the position should be used

materials - the fair market value unit price in the community of the materials donated

VI. Loans: enter amount of loan(s) received from local agencies or other sources attributable to program operations.

VII. Other Revenue: enter amount of any other revenue from income--earning efforts such as sales, interest, etc.--not previously listed.

Do not total the amount column

Income Source Form Checklist

- Has the project I.D. Number been indicated on the form?
- Has the form been completed for only that income attributable or accruing to Head Start as a result of the Head Start/EPSDT program?
- In cases where information is not applicable, has "0" been placed in the appropriate category?
- Has revenue been reported on an accrual basis?

- Where estimated figures are provided has it been so indicated by placing EST in parentheses (EST.) next to the figure?
- Has the amount for "Total Actual/Estimated Income been left blank as instructed?

INCOME SOURCES FORM

Expiration 12/31/76
OS-37-74

PROJECT I.D. NUMBER ______________________

HEAD START/EPSDT PROJECT ______________________

REPORTING PERIOD: From ______________ to ______________

NAME OF PERSON COMPLETING FORM ______________________
(Print or Type)

IMPORTANT: TO BE COMPLETED FOR ONLY THAT INCOME ACCRUING TO HEAD START AS A RESULT OF HEAD START/EPSDT.

INCOME			AMOUNT
I.	Revenue from Governmental Sources:		
	A. Federal Support (OCD)		$
	B. Other Federal Support		
	C. State Government		
	D. Local Government		
II.	Third-Party Payors:		
	A. Medicaid		$
	B. Other (List):	1	
		2	
III.	Direct Patient Payments		
IV.	Cash Contributions:		
	A. Foundations		
	B. Endowments		
	C. Private Sources		
V.	Donated Services and Materials:		
	A. Personnel		
	B. Materials (Educational)		
	C. Other (List):	1	
		2	
		3	
VI.	Loans		
VII.	Other Revenue:		
	A.		
	B.		
	C.		
TOTAL ACTUAL/ESTIMATED INCOME			

HEAD START/EPSDT EXPENDITURE FORM

The purpose of the expenditure form is to collect requisite cost information on how available resources are used to fulfill the requirements of the Head Start/EPSDT collaborative effort. This form will be an important source in ascertaining what the per child cost is among the various Head Start/EPSDT projects for delivery of EPSDT services. The form is designed to collect information on costs incurred through the Head Start/EPSDT grant award and other resources--state, local, private, etc.--available to the Head Start/EPSDT projects. The data collected will be analyzed and correlated with other program information for purposes of developing replicable approaches in the delivery of EPSDT services to Medicaid eligible children and their families.

For purposes of completing the expenditure form it is necessary to define the three cost categories inherent in this form:

- Direct Costs
- Supportive Costs
- Administrative Costs

Direct Costs

Direct costs are those costs which are directly ascribable to services rendered to children and their families involved in the Head Start/EPSDT program. These include:

- Salaries - those wages paid to staff personnel directly involved in rendering medical units of service to children and their families engaged in Head Start/EPSDT
- Fringe Benefits - those benefits applicable to the above salaries
- Consultant and Contract Services - those costs incurred as a result of fees paid to physicians under contract who are directly involved in health services to children and their families; fees paid in connection with laboratory services directly attributable to child and family health care
- Supplies - those costs absorbed relative to the purchase of prosthetics, pharmaceuticals, consumables, etc., used in the course of rendering direct health services to the child and family.

Note: Consumable supplies are those supplies used in the delivery of direct health care, e.g. disposable gloves, sheets, etc.

Supportive Costs

Supportive costs are those costs which are necessary to insure quality and ongoing services to children and their families connected with the Head Start/EPSDT effort. These include:

- Salaries - those wages paid to staff personnel who are not directly serving patients, but perform functions which induce better or continuing patient services, e.g. salaries paid or applicable to the outreach effort, child and patient education (outside of the clinic setting), transportation of patients to and from the clinic, babysitting, etc.
- Fringe benefits - those benefits applicable to the above salaries
- Travel - those costs which are incurred (exclusive or salary) in the transportation of patients to and from the clinic setting and the transportation for outreach workers, e.g. gas, mileage, tolls, etc.
- Educational Materials - the cost of educational materials used in the outreach effort or at the clinic site
- Staff Training - those costs incurred regarding contractual arrangements for training of staff personnel directly involved in providing services to children and their families, e.g. counselors, health educators
- Telephone - those costs attributable to telephone calls made in connection with the outreach effort to solicit patronage of available EPSDT services to remind patients of appointments, etc.

Administrative

Administrative costs are those which support overall program operations but are not directly associated with direct medical services to the children and their families associated with the Head Start/ EPSDT program. These inculde:

- Salaries - those wages paid to staff personnel for administrative services

- Fringe benefits - those benefits applicable to the above salaries
- Transportation - those travel costs incurred by administrative personnel in the performances of their functions, e.g. cost of travel to conferences and meetings
- Materials - cost of materials used in rendering the administrative affairs of the Head Start/EPSDT effort
- Telephone - those costs incurred as a result of telephone calls made in connection with administrative duties.

It is important to note that the expenditure form will not take into consideration those costs applicable to utilities as it would be extremely difficult to prorate or identify that portion of utility costs applicable to the EPSDT services of the Head Start program. Expenditures should also be reported on an accrual basis. That is, expenses should be reported when a clear obligation to pay has been incurred. For example, purchases of services or supplies should be recorded as soon as services have been rendered or supplies have been received. (This, however, assumes that the services were performed in good faith and that the supplies received met the contractual arrangements agreed upon.) In addition, when actual expenditure figures cannot be given estimates should be substituted and should be indicated by placing EST in parentheses (EST) in the amount column before the amount reported.

Instructions

It is important to note that the Head Start/EPSDT Expenditure Form should be completed for only those expenses attributable to or incurred by Head Start as a result of the Head Start/EPSDT program.

The form should be completed by the health coordinator in cooperation with the fiscal officer of the Head Start project.

This form is to be completed only once during the program year--at the end of the Head Start/EPSDT fiscal period (June 30, 1975). Boone, Young & Associates will, however, request a select number of projects (30) to periodically forward a copy of their monthly, year-to-date expenditure reports. This procedure will provide a means for verifying the information reported. The 30 projects selected will be notified.

While the form will be completed only once during the program year, it is important that all expenditures reported are reflective of the entire program year. The reporting period should reflect activity beginning July 1, 1974 to June 30, 1975.

The health coordinator will be responsible for seeing that the Head Start/EPSDT Expenditure Form is completed and forwarded to Boone, Young & Associates.

In addition, where actual expenditure cannot be provided by the fiscal officer, estimates should be applied. In this instance, it should be so indicated by placing EST in parentheses (EST) next to the figure(s). In all cases where the information is not applicable "O" should be indicated in the appropriate place.

Enter the project I.D. number, the name of the Head Start/EPSDT project and the reporting period at the top-right hand corner of the expenditure form.

All expenditures should be reported for the complete program year.

Column 1: enter the amount of expenses incurred through the Head Start/EPSDT budget for each of the operating expenses.

Column 2: indicate the amount of expenses incurred for the respective cost elements through in-kind contributions to the Head Start/ EPSDT effort. In assessing the value of non-cash contributions it is important that the cost as applicable in the community apply, e.g.:

- volunteers - the hourly rate already being paid to employees in like positions or the hourly rate on the open market in the community for the position

- materials - the fair market value unit price in the community of the materials donated.

Column 3: indicate the amount of expenses incurred for the applicable cost elements via cash contributions to the Head Start/EPSDT effort.

Columns 4-8: enter the amount of support (expenditures) realized by the Head Start/EPSDT effort through federal, state, local, EPSDT Medicaid, and other available sources not indicated.

Do not total Column 9 or totals relating to any of the other columns.

Head Start/EPSDT Expenditure Form Checklist

- Has the project I.D. number been indicated on the form?
- Has the form been completed for only those expenses attributable or incurred to Head Start as a result of the Head Start/EPSDT program?
- In all cases where information is not applicable has "0" been placed in the appropriate category?
- Have expenditures been reported on an accurual basis?
- Where estimated figures are provided has it been so indicated by placing EST in parentheses (EST) next to the figure?
- Has Column 9, or totals related to any other columns, been left blank as instructed?

085-S-74014 I
Expiration 12/31/76
OS-37-74

HEAD START/EPSDT EXPENDITURE FORM

PROJECT I.D. NO.______________

HEAD START/EPSDT PROJECT__________________________ REPORTING PERIOD__________________

IMPORTANT: To be completed for only those expenses incurred by Head Start as a result of the Head Start/EPSDT Program

OPERATING EXPENSES	HEAD START/ EPSDT EXPENDITURES TO DATE	NON-CASH IN-KIND CONTRI- BUTIONS	CASH CONTRI- BUTIONS	OTHER FUNDS AND SERVICES PROVIDED					TOTAL HEAD START/EPSDT EXPENDITURES FROM ALL SOURCES
				FEDERAL	STATE	LOCAL	EPSDT MEDICAID	OTHER	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
DIRECT COSTS:									
Salaries and Wages									
Fringe Benefits									
Consultant & Contract Services:									
Physician Fees									
Laboratory Services									
Other									
Supplies:									
Prosthetics									
Pharmaceuticals									
Consumables									
SUPPORTIVE COSTS:									
Salaries and Wages									
Fringe Benefits									
Transportation (Outreach &Patient Transportation)									

HEAD START/EPSDT EXPENDITURE FORM (CON'T)

IMPORTANT: To be completed for only those expenses incurred by Head Start as a result of the Head Start/EPSDT Program

OPERATING EXPENSES	HEAD START/ EPSDT EXPENDITURES TO DATE	NON-CASH IN-KIND CONTRI-BUTIONS	CASH CONTRI-BUTIONS	OTHER FUNDS AND SERVICES PROVIDED					TOTAL HEAD START/EPSDT EXPENDITURES FROM ALL SOURCES
				FEDERAL	STATE	LOCAL	EPSDT MEDICAID	OTHER	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
SUPPORTIVE COSTS (CON'T):									
Educational Materials									
Staff Training (Contractual)									
Telephone									
ADMINISTRATIVE COSTS:									
Salaries and Wages									
Fringe Benefits									
Transportation									
Materials									
Telephone									
TOTAL OPERATING EXPENSES									

APPENDIX D

TABLE I

Entry Instructions

A. Source:

Table I

Code: Enter total number of states participating

B. Source:

Table I

Code: Enter total number of projects participating

C. Source:

SRS or Baseline Data

Note: If SRS, then break out number never served and number under served on only medicaid enrolled

Code: Enter totals

D. (1-3) Source:

Baseline Data

Code: (1) Enter total Planned Participation or (2) + (3)

(2) Enter total Headstart

(3) Enter total Non Headstart

E. (1-3) Source:

Intake Forms

Code: (1) Aggregate 18 (1 + 2)

(2) Aggregate 18 (1)'s

(3) Aggregate 18 (2)'s

Table I. (Con't.)

F. (1-3) Source:

End of Year Status Form - Head Start And Non Headstart

Code: (1) Enter total of Headstart (A) and Non Headstart (A)

(2) Enter total From Headstart (A)

(3) Enter total From Non Headstart (A)

G. (1-3) Source:

Same as above

Code: (1) Enter total from Headstart (F+C2+D+E) or (A-B) and Non Headstart (C2)

(2) Enter total from Headstart (F+C2+D+E) or (A-B)

(3) Enter total from Non Headstart (C2)

H. (1-3) Source:

Table I

Code: (1) Enter total percent of $\frac{\text{Planned (D)}}{\text{Cumulative (F)}}$

(2) Enter percent Head Start $\frac{\text{Planned (D)}}{\text{Cumulative (F)}}$

(3) Enter percent Non-Head Start $\frac{\text{Planned (D)}}{\text{Cumulative (F)}}$

*Table I-A - Entry Instructions - same as Table I.

TABLE II

Entry Instructions

A. (1-3) Source

Table I - Column F

Code: Enter totals from Table I - Column F.

B. (1-3) Source:

Intake Forms

Code:
(1) Aggregate 17 (1+2)'s
(2) Aggregate 17 (1+2)'s that have (1) in 18
(3) Aggregate 17 (1+2)'s that have (2) in 18

C. (1-3) Source:

End of Year Status Form -
Headstart and Non Headstart

Code:
(1) Enter totals from (C+D) of Headstart, and (A) of Non Headstart or of (2) + (3)
(2) Enter totals from (C) + (D) of Headstart
(3) Enter totals from (A) of Non Headstart

D. (1-3) Source:

End of Year Status Forms

Code:
(1) Enter totals from (D+C2) of Headstart, and (B) of Non Headstart or of (2) + (3)
(2) Enter totals from (D + C2) of Headstart
(3) Enter totals from (B) of Non Headstart

Table II (Con't.)

E. (1-3) Source:

Intake Form

Code: (1) Aggregate 17 (3+4)'s that have (1) in 18

(2) Aggregate 17 (3)'s that have (1) in 18

(3) Aggregate 17 (4)'s that have (1) in 18

F. (1-3) Source:

End of Year Status Form - Headstart

Code: (1) Enter total from (E) + (F) of Headstart or (2) + (3)

(2) Enter total from (E)

(3) Enter total from (F)

G. Source:

Table II

Code: Enter percent of $\frac{\text{Column (C2)}}{\text{Column (A2)}}$

*Table II - A - Entry Instructions - same as Table II

TABLE III

Entry Instructions

A. (1-3) Source:

Column F - Table I

Code: Enter totals for Headstart and Non Headstart

B. (1-3) Source:

Column C - Table II

Code: Enter totals for Headstart and Non Headstart

C. (1-3) Source:

Intake Forms

Code: (1) Enter Total of 17 (1)'s

(2) Aggregate 17 (1)'s that have (1) in 18

(3) Aggregate 17 (1)'s that have (2) in 18.

D. (1-3) Source:

End of Year Status Forms- Headstart and Non Headstart

Code: (1) Enter total of (C) from Headstart and Non Headstart or (2) + (3)

(2) Total from (C) of Headstart

(3) Total from (C) of Non Headstart

E. (1-3) Source:

End of Year Status Forms - Head Start and Non-Head Start

Code: (1) Enter total of (C2) from Headstart, and Non Headstart or (2) + (3)

(2) Total from (C2) fo Headstart

(3) Total from (C2) of Non Headstart

Table III(Con't.)

F. (1-3) Source:

Table III

Code: (1) Enter per cent of $\frac{\text{Column D (1)}}{\text{Column A (1)}}$

(2) Enter per cent of $\frac{\text{Column D (2)}}{\text{Column A (2)}}$

(3) Enter per cent of $\frac{\text{Column D (3)}}{\text{Column A (3)}}$

G. (1-3) Source:

Same as Above

Code: (1) Enter per cent of $\frac{\text{Column D (1)}}{\text{Column B (1)}}$

(2) Enter per cent of $\frac{\text{Column D (2)}}{\text{Column B (2)}}$

(3) Enter per cent of $\frac{\text{Column D (3)}}{\text{Column B (3)}}$

*Table III - A - Entry Instructions - Same as Table III

TABLE IV

Entry Instructions

A. (1-6) Source:

Intake Forms

Code: Enter -
(1) Aggregate 18 (1)
(2) Total 18(1) with (1) in 19
(3) Total 18(1) with (2 and blank in 19)
(4) Total 18(1) with (1) in 17
(5) Total 18(1) with (2) in 17
(6) Total 18(1) with (3 & 4) in 17

B. (1-6) Source:

Intake Form

Code: Enter -
(1) Total 18(1) with (1) in 22
(2) Total 18(1) with (1) in 19 and (1) in 22
(3) Total 18(1) with (2 and blank) in 19 and (1) in 22
(4) Total 18(1) with (1)in 17 and (1) in 22
(5) Total 18(1) with (2) in 17 and (1) in 22
(6) Total 18(1) with (3 & 4) in 17 and (1) in 22

Table IV (Con't.)

C. (1-6) Source:

Intake Form

Code: Enter total from (1) B1/A1 x 100

(2) B2/A2 x 100

(3) B3/A3 x 100

(4) B4/A4 x 100

(5) B5/A5 x 100

(6) B6/A6 x 100

* Table IV-A Entry Instructions - same as Table IV

TABLE V

Entry Instructions

A. (1-4) Source:

Intake Form

Code: Enter Totals -
(1) Aggregate 18(1)'s
(2) Aggregate 18(1)'s with (1)'s in 17
(3) Aggregate 18(1)'s with (2) in 17
(4) Aggregate 18(1)'s with (3 & 4) in 17

B. (1-4) Source:

Intake Form

Code: Enter totals -
(1) Aggregate 18(1)'s with (1) in 23, 24, 25, 26, 27, 28, or 29.
(2) Aggregate 18(1)'s with (1) in 17, and (1) in 23, 24, 25, 26, 27, 28, or 29
(3) Aggregate 18(1) with 2's in 17 and (1) in 23, 24, 25, 26, 27, 28, or 29.
(4) Aggregate 18(1)'s with (3) and (4)'s in 17 and (1) in 23, 24, 25, 26, 27, 28 or 29.

(Table V-Con't.)

C. (1-4) Source

Intake Form

Code: Enter totals -

(1) Aggregate 18(1)'s with (1) in 31, 32, or 33

(2) Aggregate 18(1)'s with (1)'s in 17 and (1)'s in 31,32, or 33

(3) Aggregate 18(1)'s with (2)'s in 17 and (1)'s in 31, 32, or 33

(4) Aggregate 18(1)'s with (3 & 4) in 17 and (1)'s in 31, 32, or 33

D. (1-4) Source:

Intake Forms

Code: Enter totals -

(1) Aggregate 18(1)'s with (1)'s in 34, 35 or 36

(2) Aggregate 18(1)'s with (1)'s in 17 and (1)'s in 34, 35, or 36

(3) Aggregate 18(1)'s with (2)'s in 17 and (1)'s in 34 35 or 36

(4) Aggregate 18(1)'s with (3) & (4)'s in 17 and (1)'s in 34,35 or 36

(Table V - Con't.)

E. (1-4) Source:

Intake Forms

Code: Enter totals -

(1) Aggregate 18(1)'s with (1)'s in 37 or 38

(2) Aggregate 18(1)'s with (1)'s in 17 and (1)'s in 37 or 38

(3) Aggregate 18(1)'s with (2)'s in 17 and (1)'s in 37 or 38

(4) Aggregate 18(1)'s with (3) & (4)'s in 17 and (1)'s in 37 or 38

* Table V-A - Entry Instructions - Same as Table V.

TABLE VI

Entry Instructions

A. (1-3) Source:

Intake Forms

Code:	Enter totals -	(1)	Total 18(2)
		(2)	Aggregate 18(2) with (1)'s in 17
		(3)	Aggregate 18(2) with (2)'s in 17

B. (1-3) Source:

Intake Forms

Code:	Enter total -	(1)	Aggregate 18(2) and 22(1)
		(2)	Aggregate 18(2) with (1)'s in 17 and 22(1)
		(3)	Aggregate 18(2) with (2)'s in 17 and 22(1)'s

C. (1-3) Source:

Intake Forms

Code:	Enter Per cents	(1)	B1/A1 x 100
		(2)	B2/A2 x 100
		(3)	B3/A3 x 100

Table VI (Con't.)

D. (1-3) Source:

Intake Forms

Code: Enter Totals - (1) Aggregate 18(2)'s with (1)'s in 23, 24, 25, 26, 27, 28 or 29

(2) Aggregate 18(2)'s with (1)'s in 17 and (1)'s in 23, 24, 25, 26, 27, 28 or 29

(3) Aggregate 18(2)'s with (2)'s in 17 and (1)'s in 23, 24,25 26, or 27

E. (1-3) Source:

Intake Forms

Code: Enter totals - (1) Aggregate 18(2)'s with (1)'s in 31,32 or 33

(2) Aggregate 18(2)'s with (1)'s in 17 and (1)'s in 31,32, or 33

(3) Aggregate 18(2)'s with (2)'s in 17 and (1)'s in 31, 32, 33

F. (1-3) Source:

Intake Forms

Code: Enter totals - (1) Aggregate 18(2)'s with (1)'s in 34, 35, or 36

(2) Aggregate 18(2)'s with (1)'s in 17 and (1)'s in 34, 35 or 36

(3) Aggregate 18(2)'s with (2)'s in 17 and (1)'s in 34, 35 or 36

(Table VI. Con't.)

G. (1-3) Source:

Intake Forms

Code: Enter Totals -

(1) Aggregate 18(2)'s with (1)'s in 37 or 38

(2) Aggregate 18(2)'s with (1)'s in 17 and (1)'s in 37 or 38

(3) Aggregate 18(2)'s with (2)'s in 17 and (1)'s in 37 or 38

* Table VI -A - Entry Instructions - Same as Table VI.

TABLE VII

A. (1-3) Source:

Table I - Column A(1-3)

Code: Enter totals from Table I column A(1-3)

B. (1-2) Source:

Totals from Table VII

Code: Enter (1) Total number of projects funded

(2) Total number of projects reporting

C. (1-5) Source:

Staff Profile

Code: Enter number of years for level of education attained.

D. (1-2) Source:

Staff Profile

Code: Enter Capital X in appropriate column to indicate

(1) Full Time

(2) Part Time

TABLE VII-A

Entry Instructions

A. (1-3) Source:

Table I - Column F (1-3)

Code: Enter totals from Column F of Table I

B. (1-5) Source:

Staff Profile Form

Code: (1-3) Enter the total number of years completed by the EPSDT coordinator for each educational level

(4-5) Enter Capital X if the EPSDT coordinator is an LPN or RN.

C. (1-2) Source:

Staff Profile Forms

Code: Enter (1) Number of years with Headstart

(2) Number of years with other health related agencies/organizations.

D. (1-4) Source:

Ad Hoc Questionnaire

Personnel Section #1

Staff Profile Form

Code: Enter FT = Full time

PT = Part time

Table VII-A (Cont.)

E. (1-2) Source:

Ad Hoc Questionnaire

Personnel Section #4, 5, 6

Code: Enter L = Limited
M = Moderate
C = Considerable
W = Workshop
N = None
NI = No Information

F. (1-4) Source:

Ad Hoc Questionnaire

Personnel Section #2

Code: Enter (1) Totals from Table VII-A Column F (2, 3, 4)
(2) Number of resignations
(3) Number of terminations
(4) Number of transfers

TABLE VIII

Entry Instructions

A. (1-5) Source:

Ad Hoc Questionnaire (AHQ)

Institutional Characteristics (IC) #4

Medicaid Profile (MP)

Code: Enter - Capital X in one of the columns entitled

1 = Current

2 = Out-of-date

3 = None

4 = Uncertain

5 = Not Applicable

B. (1-4) Source:

(1) MP - Page 1

(2) AHQ - IC #3, #9

(3) AHQ - IC #5, #9

(4) MP - Page 2

Code: Enter Yes

No

UNC = Uncertain

NA = Not Available

Table VIII (Cont.)

C. (1-6) Source:

(1) AHQ - Management #4, 5; Site visit

(2) AHQ - IC #3, 4; Site visit

(3) AHQ - Management #4; Site visit

(4) Site visit

(5) Site visit

(6) Site visit

Code: Enter Yes

No

UNC = Uncertain

NA = Not Available

TABLE IX

Entry Instructions

A. Source:

(1) Ad Hoc Questionnaire (AHQ)
Program Section

(2) Site Visit (Narrative) Report

Code: Enter - Autonomous

CAA = Community Action Agency

SS = School System

PA = Public Agency

B. (1-4) Source:

Ad Hoc Questionnaire (AHQ)

Program Section #3

Code: Enter Capital X in one of columns entitled

1 - Work book, proposal and questionnaire

2 - Additional written plan

3 - Other

4 - None

C. (1-9) Source:

(1) AHQ - Management Section #2

(2) AHQ - Management Section #2, Outreach #2,
Site Visit Report

(3) AHQ - Institutional Characteristics #5, 6,
Site Vist Report

(4) AHQ - Management Section #2

(5) Site Visit Report

Table IX (Cont.)

(6) AHQ - Follow-up #1, 5

(7) AHQ - Management Section #3
Follow-Up #1, 3, 5, Site visit report

(8) AHQ - Management Section #2

(9) AHQ - Management Section #2

Code: Enter - HS = Headstart
PA = Public Agency
CAA = Community Action Agency
VA = Voluntary Agency
N = None

TABLE IX-A

Entry Instructions

A. (1-8) Source

Ad Hoc Questionnaire (AHQ)

Management Section (MS) #2

Narrative

Code: Enter V = Vendor*

P = Non-Vendor Provider*

N = No Provider

NA = Not Applicable

e.g., If treating only younger siblings, dental screenings may not apply

M = Medicaid Eligible only

NI = No Information

*If V or P is Headstart program, enter:

HS/V = Headstart/Vendor

HS/P = Headstart/Non-Vendor provider

B. (1-4) Source

AHQ #2

Narrative

Code: Enter - same as above

Table IX-A (Cont.)

A. (1-8) Source

AHQ #2

Narrative

Code: Enter - Same as above

B. (1-4) Source

AHQ #2

Narrative

Code: Enter - Same as above

TABLE IX-B

Entry Instructions

A. (1-3) Source:

Table I - Column F

Code: Enter totals from Column F of Table I

B. (1-2) Source: Data base

Code: Enter totals and % from Table M

C. Source:

Table III - Column C #3

Code: Enter total from Column C #3

D. Source:

Ad Hoc Queztionnaire (AHQ)

Outreach Section #2, 3

Site Report Narrative

Code: Enter Yes

No

E. (1-9) Source:

Ad Hoc Questionnaire

Outreach Section #2, 3

Code: Enter Capital X - for each method utilized (no ranking)

E = English speaking only (when Yes in Column D)

P = Priority method (most effective)

P/E = Priority method for English speaking only

Table IX-B (Cont.)

F. Source:

Ad Hoc Questionnaire (AHQ)

Outreach Section #6

Code: Enter - Yes
No

G. (1) Source:

Table III - Columns C #2 and D #2

Code: Enter total by subtracting Column C #2 from D #2

(2) Source:

Table III - Columns C #3 and D #3

Code: Enter total by subtracting Column C #3 from D #3

(1) Source:

End of year status report

Headstart #Cl

Code: Enter totals from Cl

(2) Source:

End of year status report

Non-Headstart #Cl

Code: Enter totals from #Cl

TABLE IX-C

Entry Instructions

A. (1-3) Source:

Table I - Column F (1-3)

Code: Enter totals from column F (1-3)

B. (1-3) Source:

Table XVII - Outcomes

Follow-Up Required Columns

Code: Enter follow-up required totals

C. Sources:

(1-2) Ad Hoc Questionnaire (AHQ)

Follow-up section

Head Start Program - #1

Other than Headstart program - #5

Code: Enter HS = Headstart

PA = Public Agency

VA = Voluntary Agency

N = None

NI = No Information

(3-4) Source:

Judgement

Code: Enter E = Excellent

G = Good

A = Adequate

P = Poor

NA = Not Applicable

Table IX-C (Cont.)

D. Source:

(1-2) Ad Hoc Questionnaire (AHQ)
Recordkeeping Section #1E, 2E
Used Column

Code: Enter Yes
No
NA - Not Applicable
NI - No Information

(3-4) Sources:
Ad Hoc Questionnaire (AHQ)
Recordkeeping Section #1, 2
Position Column
Management Section #2

Code: Enter HS = Headstart
PA = Public Agency
VA = Voluntary Agency
N = None
NA = Not Applicable
NI = No Information

Table IX-C (Cont.)

(5-8) Source:

Ad Hoc Questionnaire (AHQ)

Management Section #3

Follow-up Section #3

Code: Enter Yes

No

NA = Not Applicable

NI = No Information

(9-10) Source

Judgement

Code: Enter E = Excellent

G = Good

A = Adequate

P = Poor

NI = No Information

NA = Not Applicable

TABLE IX-D

Entry Instructions

A. Source

(1) End of year status form (EYSF)
Headstart #H: "Retained by program"

(2) EYSF - Non Headstart #D

(3) EYSF - Headstart #H

Transferred to school system (TSS)

Given to parent (GPA)

Given to provider (GP)

Code:

Columns 1 and 2 - Enter Yes or No

Column #3 - Enter S = School system (if (1) in TSS)

PA = Parent (if (1) in GPA)

P = Provider (if (1) in GP)

B. Source:

(1) Ad Hoc Questionnaire - Recordkeeping Section (RS) #1.
Use Column New with EPSDT for items A, B, and E

Code: Enter - Yes

No

NI - No Information

Table IX-D(Cont.)

(2-3) Source:

Ad Hoc Questionnaire - Recordkeeping Section

#1 Headstart

#2 Non-Headstart

Column - New with EPSDT for Item C

Code: Enter - Yes

No

NI - No Information

NA - Not Applicable

C. (1-2) Source:

Judgement of site visitors

Code: Enter E = Excellent

G = Good

A = Adequate

P = Poor

NA = Not Applicable

(3-5) Source:

Review of Documents

Code: Enter E = Excellent

G = Good

A = Adequate

P = Poor

NA = Not Applicable

NI = No Information

TABLE X

Entry Instructions

A. (1-3) Source:

Written state plan

Code: Enter Capital X in Columns 1, 2, or 3

B. (1-7) Source:

Written state plan

Code: Enter Capital X = If definitions are provided

N = None

NI = No Information

C. (1-2) Source

Written state plan

Code: Enter (1) Capital X = If the state plan has provisions for outreach

N = None

(2) OG = Other governmental

I = Internal

P = Private

J = Joint

D. (1-2) Source:

Written state plan

Code: Enter (1) Capital X = If state plan has provisions for publicity

(2) Same as C2

Table X (Cont.)

E. (1-2) Source:

Written state plan

Code: Enter (1) Capital X - If provisions are made for transportation

(2) Same as C2

F. Source:

Written state plan

Federal regulations

Code: Enter GAP

Same

NI - No Information

G. (1-3) Source:

Written state plan

Site visit

Code: Enter (1) Capital X - If provisions exist

(2) Same as C2

(3) C = Computer

M = Manual

N = None

NI = No Information

TABLE XI

Entry Instructions

A. (1-4) Sources:

Ad Hoc Questionnaire (AHQ)

Institutional Characteristics (IC)

State Medicaid Plans (SMP)

Code: Enter - Retained

Partially delegated

Totally delegated

B. (1-2) Sources

Ad Hoc Questionnaire

Institutional Characteristics

State Medicaid Plans

Code: Enter - Capital X in either B (1) or B (2)

C. Source:

Ad Hoc Questionnaire

Institutional Characteristics

State Medicaid Plan

Code: Enter - Annually (12 months)

Bi-annually (6 months)

Quarterly (3 months)

Monthly (1 month)

Table XI (Cont.)

D. Source:

State Medicaid Plan

Code: Enter numbers from code on face of Table X

E. (1-3) Source:

Staff judgement of state Medicaid plan

Code: Enter Capital X in either E(1), E(2), or E(3)

TABLE XII

Entry Instructions

I. State Level Interagency EPSDT Relationships:
Source:

Type of agency - Enter: PW = Public Welfare

PH = Public Health

YFS = Youth Family Services

SHA = State Health Agencies

MA = Department of Medical Assistance

LWB = Local Welfare Board

LHB = Local Health Board

LMAU = Local Medical Assistance Unit

J = Joint Responsibility

PI = Private Insurance

CSP = Children's Services Division

CHDP = Child Health Disability Prevention Program.

Type of relationship - Enter: SA = State Administered

LA = Locally Administered

NA = Not Applicable

I = Informal Agreement

C = Contractual Agreement

Functions - Enter: Captial X

Table XII (Cont.)

II. State Agency - Local Government Agency Relationships:
Source:

Type of Agency - Enter: Same as code listed under State level interagency EPSDT Relationships-(Type of Agency).

Type of Relationship - Enter: Same as code listed under state level Interagency EPSDT Relationships (Type of Relationship)

Function - Enter: Capital X

TABLE XIII

Entry Instructions

A. Source:

Table X - Column D

Code: Enter - U = Uncooperative
L = Limited
R = Restricted
UL = Unlimited

B. (1-2) Source:

Ad Hoc Questionnaire

Institutional Characteristics

Code: Enter - Yes
No

C. Source:

Ad Hoc Questionnaire

Institutional Characteristics #11, 13

Site visit report

Code: Enter - Required
Preferred
No
NA = Not Applicable

Table XIII (Cont.)

D. (1) Source:

Ad Hoc Questionnaire

Institutional Characteristics #1

Narrative

Code: Enter - Yes

No

(2) Source:

State Medicaid Plan

Ad Hoc Questionnaire

Insitutional Characteristics #17

Narrative

Memory

Code: Enter - UC = Usual and customary

FF = Fixed Fee

NI = No Information

(3) Source:

Ad Hoc Questionnaire

Institutional Characteristics #18

Code: Enter - Yes

No

FF - Fixed Fee

UC - Usual and customary

NA = Not Applicable

Table XIII (Cont.)

E. (1-2) Source:

Ad Hoc Questionnaire

Institutional Characteristics #18

Code: SA = Services not available

C = Cooperative

P = Positive

U = Uncooperative

NA = Not Applicable

RD = Reimbursement Delayed

RU = Rates unacceptable

NS = Not providing all services

SU = Screening practice unacceptable

FU = Forms unacceptable

RM = Refuse/reluctant to serve Medicaid

PU = Physician uninformed about EPSDT

O = Opposed to state policies

TABLE XIV

Entry Instructions

A. (1-6) Source:

Ad Hoc Questionnaire (AHQ)

Site Visit Narratives (SVN)

Code: Enter Capital X in all applicable columns entitled:

1 - State

2 - Headstart Program

3 - Health Liaison Specialist

4 - Local Agencies

5 - Joint

6 - No one

B. (1-6) Source:

Same as above

Code: Same as above

C. (1-4) Source:

Same as above

Code: Enter Capital X in one of the columns entitled:

1 - Written Agreement

2 - Verbal Agreement

3 - Not Clarified

4 - None

Table XIV (Cont.)

D. (1-9) Source:

Same as above

Code: Enter Capital S-where outcomes were with the state

L-Where outcomes were with local agencies

N Where there were no outcomes

S/L-Where outcomes were with state and local agencies

TABLE XV

Entry Instructions

A. (I-3) Source:

Health Liaison Specialist - Ad Hoc Questionnaire
Management Sections #4, 5

State Agencies - Ad Hoc Questionnaire
Institutional Characteristics #23, 24 Narrative

Local Agencies - Ad Hoc Questionnaire
Institutional Characteristics #25, 26; Narrative

Code: HLS = Health Liaison Specialist

SA = State Agencies

LA = Local Agencies

B. (1-6) Source:

Same as above

Memory

Code: Same as above

C. (1-6) Source:

Site visit

Narrative

Memory

Code: Enter Capital X